University of Alberta

THE CHALLENGES FOR PRECEPTORS IN DEALING WITH NURSING STUDENTS ENGAGING IN UNSAFE PRACTICES

by

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Abstract

Although preceptorship programs are now used extensively in nursing education, very little is yet known about how preceptors teach students who engage in unsafe practice, and even less is known about how they manage such students. Preceptors have often described precepting senior students as a rewarding or gratifying experience. However, dealing with a student whose level of practice is marginal or unsafe may make precepting a tedious and challenging experience. Moreover, when the student's level of practice is questionable, the preceptor also faces the dilemma of facilitating entry into the profession of a graduate who may be unsafe in practice. As well, the preceptor faces a number of other consequences, including an appeal process that may be time consuming or potential legal implications, such as being sued for contributing to either passing or failing such students.

The purpose of this retrospective study was to construct a grounded theory to explain the processes that preceptors use to manage students who engage in unsafe practices. The researcher explored the processes that preceptors employ in precepting a student with unsafe practices. The sample was comprised of preceptors in final-year undergraduate and after-degree nursing programs in a large university in western Canada. The researcher obtained data through individual tape-recorded interviews and conducted the data analysis using the constant comparative analysis that Glaser and Strauss (1967) and Glaser (1978) described.

This study has the potential to make a valuable contribution to the management of nursing students who engage in unsafe practices during preceptorship experiences. Based on the findings, the researcher recommends that students be properly screened prior to

placement, that students whose level of practice is marginal be detected early, that strategies be developed to deal with such students, and that preceptors who work with these students receive appropriate support.

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Dedication

To my parents for laying the foundation that started me on this journey, and to my husband and children, who have encouraged and supported all of my efforts.

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CHAPTER 1:

INTRODUCTION

Preceptorship programs are widely used in undergraduate and postgraduate nursing programs in Australia, Canada, the United States of America ([USA] Usher, Nolan, Reser, Owens, & Tollefson, 1999), and the United Kingdom ([UK]; Bowles, 1995) as an available, alternative clinical teaching strategy to the traditional approach to clinical teaching (Myrick & Barrett, 1994). In one province in western Canada, for example, the Nursing Education Program Approval Board requires that undergraduate nursing students have consolidated practice with a preceptor at the end of the program to attain licensure. The purpose of most senior nursing students' practicum experiences is to facilitate their learning of the roles and functions of staff nurses while working in a preceptor relationship with a nurse in the clinical setting (Anderson, 1991; Bryant & Williams, 2002). Studies have confirmed the positive outcomes of preceptored senior practicum experiences, including role socialization (Bryant & Williams, 2002; Letizia & Hennrich, 1998; Nodgren, Richardson & Laurella, 1998), increased competence and self-confidence (Bryant & Williams, 2002; Ferguson & Calder, 1993; Letizia & Jennrich, 1998) and role mastery (Laschinger & MacMaster, 1992).

Although many preceptored students are at an advanced stage of their education or near completion of their program and should have advanced knowledge and skills, their level of expertise can vary greatly. Some require closer supervision than others if high standards of patient care are to be maintained (Lewis, 1990; Yonge, Krahn, Trojan, Reid, & Haase, 2002a). Although preceptorship programs have grown in popularity and continue to do so, very little is known about how preceptors deal with students whose

level of performance is questionable or unsafe (Rittman & Osburn, 1995; Scalan, Care, & Gessler, 2001).

Background to the Problem

Langlois and Thach (2000a) noted that, most of the time, teaching is a rewarding experience. They explained that teaching learners keeps preceptors on their toes and watching learners develop knowledge and skill is gratifying. Nurse preceptors also usually describe precepting senior students as the rewarding or gratifying experience (Allen, 2002; Bashford, 2002; Rittman & Osburn, 1995) of "providing the finishing touches prior to their entering the real world of practice" (Rittman & Osburn, 1995, p. 217). For instance, many preceptors in Allen's (2002) study described a sense of reward from watching students progress. Bashford (2002) affirmed that preceptors feel pleasure and satisfaction in watching students improve their psychomotor and clinical judgment skills.

Most of the literature on preceptorship confirmed the rewarding experience of precepting students. However, nurses are busy with their own patient care assignments and other responsibilities within their job description. Being a preceptor requires extra time and energy, and occasionally a problem with a learner can arise that can be challenging and stressful for the preceptor (Yonge, Krahn, Trojan, & Reid, 1997b; Yonge et al., 2002a). Authors from other professional education programs also acknowledged that students whose clinical performance is below standard or questionable present special challenges (Shapiro, Ogletree, & Brotherton, 2002) because "they require a significant, if not disproportionate, investment of instructional time and resources" (p. 422). Similarly, the nurse preceptors in Robinson, McInerney, and Sherring's (1999)

study found it hard to simultaneously balance the need to closely supervise students with the need to allow them clinical independence. They recognized the competing demands of encouraging students' independence and the professional obligation to ensure safe and competent practice. As a result, the preceptors "had to be on their toes, because they constantly felt responsible for the student's learning experience" (Yonge at al., 2002a, p. 23) and, ultimately, responsible for patient care. For instance, when a student barely passes a clinical assignment and may be unsafe, precepting becomes a tedious and challenging process of remedial skill development rather than the provision of exciting learning opportunities (Rittman & Osburn, 1995). Moreover, when the student's level of practice is unsafe, the preceptor also faces the dilemma of facilitating entry into the profession of a graduate who may be unsafe in practice (Rittman & Osburn, 1995). This may entail a number of consequences, such as feelings of personal failure, the possibility of an appeal process that may be very time consuming, or potential legal implications (e.g., being sued for contributing to decisions either to pass or fail such students; Boyle & Whitney, 2003; Ilott & Murphy, 1997).

Conversely, a preceptor who fails a borderline student may fear that the judgement is too harsh and will jeopardize the student's future (Hrobsky & Kersbergen, 2002; Ilott & Murphy, 1997; Moeller, 1984). As a result of this concern, a borderline student may be given the 'benefit of the doubt' and allowed to pass (Boyle & Whitney, 2003; Duffy, 2004; Hawe, 2003; Ilott & Murphy, 1997; Lankshear, 1990). Thus, precepting this kind of student is often complex and problematic for the student and the preceptor (Rittman & Osburn, 1995; Yonge et al., 1997b). A student may have a knowledge deficit, may exhibit inappropriate behaviour while in the clinical setting, or

may be focused more on personal issues, any of which can adversely affect his or her clinical performance. Other authors noted that being a preceptor is stressful and that some excellent preceptors have experienced 'burnout' and stopped precepting after a difficult encounter with a student (Langlois & Thach, 2000a; Yonge et al., 2002a). How then can these difficult learning situations be prevented? How do preceptors manage those students who engage in unsafe practices, lack adequate knowledge and skill, or act unprofessionally? These are some of the issues that were explored in this study.

Purpose of the Study

The purpose of this study was to construct a grounded theory to explain the processes that preceptors use to manage students who engage in unsafe practices. The processes that preceptors use in precepting students with unsafe practices were explored, and effective managing and coping strategies that preceptors use were identified.

Research Questions

The following questions guided the study:

1. What is the process of dealing with students whose level of performance is questionable or unsafe during preceptorship?
2. What strategies do preceptors use in managing difficult learning situations?

In addition, follow-up questions helped to clarify ideas, thoughts, and feelings and to gain a fuller understanding of the phenomenon under study.

Definition of Terms

Preceptorship is an individualized teaching/learning strategy in which a nursing student is paired with a clinical staff member (preceptor) for an entire clinical rotation to

allow the student to experience day-to-day practice with the supervision of a role model and resource person (Chickerella & Lutz, 1981).

In the *traditional model*, a faculty member who is present at all times at the clinical site directs the clinical teaching and evaluation of a group of students (Nehls, Rather, & Guyette, 1997).The student-faculty ratio may be 8:1 or more (Myrick, 1998).

A *preceptor* is a registered nurse (RN) in the clinical setting who assumes the responsibility of a role model, teacher, supervisor, and resource person for the undergraduate nursing student.

The *nursing student*, or *preceptee*, is a fourth-year undergraduate or after-degree nursing student in the final semester of a baccalaureate nursing program who is enrolled in the final clinical practicum. In this particular study this practicum was a senior clinical course for nursing students in their final year of a BScN program. It involved 340 hours of comprehensive exposure to nursing practice in an area, where possible, of special interest to the individual student, and all students were expected to practice with increasing independence under the supervision of a preceptor who was an RN (Faculty of Nursing, 2004b).

In this study, *unsafe student performance* was defined relative to course expectations. Unsafe practice includes an act or behaviour that reflects a lack of knowledge, skill, or clinical judgment, or any unprofessional or unethical conduct by a student that threatens or has the potential to threaten the physical, emotional, mental, or environmental safety of the client or health care provider (Hansen, 2000). Unsafe or unethical nursing practice may be evidenced by, but not limited to, one or more of the following behaviours:

- performing nursing activities or procedures for which the student is not prepared or which are beyond the capabilities of the student (General Faculties Council [GFC], 2003).
- accepting the delegation of a nursing function when acceptance could reasonably be expected to result in unsafe or ineffective client care (Hansen, 2000).
- failing to recognize and/or record and report to the preceptor or other clinical staff an error made while providing client care (DePaul University, 2001).
- failing to utilize appropriate judgment in administering safe nursing practice based upon the expected level of nursing preparation (Hansen, 2000).
- failing to exercise technical competence in carrying out nursing care (Hansen, 2000) or being unable to perform the psychomotor skills necessary for carrying out safe nursing procedures.
- recording inaccurately, altering, or deliberately falsifying client records, including forging signatures (Hansen, 2000; GFC, 2003).
- having physical, mental, and/or cognitive limitations that endanger or impair the welfare of the client and/or others (Canadian Nurses Association [CNA], 2002).
- disclosing confidential or private information inappropriately (DePaul University, 2001).
- behaving in a disrespectful manner toward clients, faculty, and/or other health care team members, such as verbally or physically abusing clients (DePaul University, 2001).

- displaying careless or negligent behaviour that results in unnecessary physical and/or mental harm to patients or clients (GFC, 2003).
- attending clinical experience while under the influence of drugs or alcohol (DePaul University, 2001).

Underlying Assumptions

Several assumptions underlie the research process for this project on precepting nursing students in undergraduate programs:

1. Because the educational program has an academic, legal, and ethical responsibility to prepare graduates who are competent with the intention of protecting the public from incompetent practitioners, it was assumed that preceptors also recognize and accept their responsibility as gatekeepers to the profession by recognizing unsafe or incompetent nursing practice.

2. It was assumed that if faculty members require high standards in nursing education, some students will fail. Therefore, not all students will succeed in their clinical preceptorship experience.

3. Not every student will be successful either in a course taught by a faculty member or in a preceptorship experience (Cowburn, Nelson, & Williams, 2000; Ilott, 1996; O' Mara, 1997). Therefore, it was assumed that failure is an expected outcome for a minority of students.

4. It was assumed that the course-based clinical assessment tools are valid.

5. It was assumed that issues of safety would be more evident in acute care than in long-term care settings, and therefore only preceptors in acute care settings were interviewed.

6. It was assumed that the study participants would be willing to express their opinions or experiences freely in response to the interviews.

7. It was assumed that, because most preceptors do not have formal preparation for their teaching role, they do not possess a teaching philosophy or specific framework to guide them and that, as a result, for the most part they teach the way that they were taught.

CHAPTER 2:

REVIEW OF RELATED LITERATURE

A review of the literature in nursing education revealed minimal information on precepting and managing students who engage in unsafe practice. Because this topic is rarely addressed in the nursing literature, sources from other disciplines, such as education, dentistry, medicine, rehabilitation, occupational therapy, social work, and speech-language pathology and audiology were reviewed, Themes found in the literature indicate that precepting a student who engages in unsafe practice can be a problematic, daunting, and challenging experience (Ilott & Murphy, 1997; Langlois & Thach, 2000a; Shapiro et al., 2002; Yonge et al, 1997b; Yonge et al., 2002a).

Assumptions That Underlie the Preceptorship Model

Preceptorship is a one-to-one learning experience in the clinical setting in which the student is paired with a clinical staff member who guides the student (Peirce, 1991). Chickerella and Lutz (1981) defined *preceptorship* as "an individualized teaching/ learning method. Each student is assigned to a particular preceptor for the entire clinical rotation, so he or she can experience day-to-day practice with the model and resource person immediately available within the clinical setting" (p. 107). The assumption that underlies the use of the preceptorship method of teaching is that the one-to-one situation provides the most effective mechanism for learning (Myrick & Barrett, 1994). In addition, a preceptorship experience allows nursing faculty and staff nurses to collaborate on enhancing the transition from the role of student nurse to staff nurse (Chickerella & Lutz, 1981; Ferguson, 1994).

Description of Students' Unsafe Practices

The reviewed literature indicated differences in the terms used to describe a student who engages in unsafe practice. The nursing education literature used the term *unsafe student* to refer to students whose level of clinical practice is questionable in the areas of safety, or to students with marked deficits in knowledge and psychomotor skills, motivation, or interpersonal skills (Hrobsky & Kersbergen, 2002; O'Mara, 1997; Rittman & Osburn, 1995; Robinson et al., 1999; Scanlan et al., 2001; Yonge et al., 2002a, 2002b). For example, O'Mara (1997) referred to those students who lack knowledge and act unprofessionally as *unsafe*. *Unsafe practice in a clinical setting* may be defined as any act by the student that is harmful or potentially detrimental to the client, self, or other health personnel. Scanlan et al. (2001) described unsafe clinical practice as "an occurrence or a pattern of behaviour involving unacceptable risk" (p. 25) and defined it as

> behaviour that places the client or staff in either physical or emotional jeopardy. Physical jeopardy is the risk of causing physical harm. Emotional jeopardy means that the student creates an environment of anxiety or distress, which puts the client or family at risk for emotional or psychological harm. (p. 25)

Other descriptions of the unsafe student found in the medical, occupational therapy, social work, and dental education literature include, but are not limited to, *problem learner* (Hunt, Carline, Siever, & Loebel, 1989; Lucas & Stallworth, 2000; Moeller, 1984; Vaughn, Baker, & DeWitt, 1998); *difficult student*, *annoying student*, or *stressed student* (Vaughn et al., 1998); *marginal student* (Cowburn et. al., 2000; Shapiro et al., 2002); and *challenging student* (Hendricson & Kleffner, 2002), and Langlois and Thach (2000a, 2000b) defined the circumstances as *difficult learning situations*. In relation to occupational therapy education, Moeller (1984) defined a *problem learner* as

"a student who manifests skill deficiencies (inability to translate theory into practice) and/or personality deficiencies (manifested by poor interpersonal relationships) that are serious enough for the supervisor to question whether the student should be allowed to enter the field" (p. 205).

From a dental education perspective, Hendricson and Kleffner (2002) described a *challenging student* as one with one or more of the following characteristics: has difficulty in learning or performing up to expectations; is easily distracted and does not devote full attention to academic responsibilities; is difficult, frustrating, and unpleasant to work with; has an attitude problem or is defensive; and does not appear to be motivated to learn (p. 44). They contended that defensiveness and a lack of motivation to learn may be interrelated with the student's sense of safety within the academic environment and his/her 'survival' strategy (Hendricson & Kleffner, 2002). This acute defensiveness may also hinder preceptor-student communication and, in turn, the quality of the learning experience. These authors further explained that underlying medical conditions and psychological problems can contribute to poor clinical performance or undesirable behaviour and attitude. For example, "high levels of stress, hormonal imbalances, systemic diseases such as hypertension and insufficient sleep can contribute to attention disorders, concentration difficulties, and affective (emotional) abnormalities that may impair the brain's capacity for learning" (pp. 45-46).

From a medical education perspective, Vaughn et al. (1998) defined a *problem learner* as "a learner whose academic performance is significantly below performance potential because of a specific affective, cognitive, structural, or interpersonal difficulty" (p. 217). Similarly, Lucas and Stallworth (2003) described problem learners as those

learners "who perform significantly below their potential due to specific difficulties" (p. 554). They categorized problem learners into four categories similar to those that Vaughn et al. identified.

Learners with affective problems are described as those who have difficulty coping with important events, such as new phases of their education (e.g., transition into clinical rotations, marital or relational difficulties, and illness or death in the family). This difficulty in adjusting to such events may ultimately manifest into problems with motivation or memory (Lucas & Stallworth, 2003; Vaughn et al., 1998). Vaughn et al. added that these problem students may display low self-esteem, feelings of being overwhelmed, inadequacy, fear of failure, depression, and anxiety and that these psychological states in turn may affect the learning process and lead to avoidance of learning, failure to perform, memory loss, and a decreased desire to learn.

Learners with cognitive disorders have been most commonly described in the literature as those who usually display poor written or oral communication, poor integration of material, and a lack of knowledge (Lucas & Stallworth, 2003; Vaughn et al., 1998). Learners with structural problems, on the other hand, are unable to structure their experiences in the environment and may demonstrate poor time management and organizational skills. Learners with interpersonal problems are those who have difficulty interacting with others, including patients, staff, and faculty. These include but are not limited to students who are shy, nonassertive, or bright but have poor social skills (Lucas & Stallworth, 2003; Vaughn et al., 1998).

Challenges in Managing Students Who Engage in Unsafe Practices: A Nursing Perspective

Two Research Approaches to the Problem

Rittman and Osburn (1995) used a case study method to analyze the process of precepting a nursing student with unsafe practices. They obtained data from a journal written by a preceptor during a six-week senior practicum experience in the student's final semester of a baccalaureate nursing program. The student was in the clinical setting for 24 hours each week, for a six-week period, and worked alongside this experienced preceptor. The preceptor began the journal during the first week of the practicum when she became aware of the challenge of precepting this particular student, and she recorded her daily experiences, thoughts, and feelings for the duration of the practicum (Rittman & Osburn, 1995).

After the preceptor had completed the preceptorship experience, Rittman and Osburn (1995) conducted a hermeneutical analysis of the journal, and two themes important to precepting an unsafe student emerged: knowing the student and creating possibilities for success. Two aspects of knowing the student included "watchful listening and assessing dangerousness" (p. 217). Rittman and Osburn described knowing the student as crucial for the preceptor to plan learning experiences and assure patient safety. Although knowing the student is important in precepting *all* students, this aspect becomes more critical in dealing with students who engage in unsafe practices. It also means assessing the student's level of competency to determine what the preceptor can trust the student to do safely. In Rittman and Osburn's study, the preceptor used watchful listening to assess the student's level of competence. For example, the way that a student enters the

clinical setting can communicate to the preceptor the levels of dependability, respect for others, and anxiety (Rittmann & Osburn, 1995).

Rittman and Osburn (1995) considered assessing dangerousness a critical skill in precepting students and explained that this implies that the preceptor has to be extra vigilant in watching over the student to identify the potential for student error. For example, the preceptor in their study became more concerned for patient safety when the student did not know when to ask for assistance, which thereby increased the risk of error. Once the preceptor had developed confidence in the student's level of competence, she then gradually increased the scope of the student's responsibility or independence.

Rittman and Osburn (1995) identified the following as hallmarks of unsafe student practice: (a) failing to recognize gaps in patient care, (b) having difficulty in prioritizing or organizing basic patient care activities, (c) failing to report important observations or occurrences to the preceptor, and (d) failing to question practice critically and to show an alertness to the possibility of the student's making an error. It is therefore important that preceptors recognize these hallmarks or signals that a student is unsafe or having problems with safety issues.

Rittman and Osburn (1995) considered creating possibilities for success one of the "caring practices" (p. 220) of precepting a student with unsafe practices. The preceptor had used several approaches to create possibilities for success, including assigning small, less complex assignments; giving positive reinforcement to promote self-esteem; using repetition to promote organizational skills; and providing cues prior to the student's performance of a task (Rittman & Osburn, 1995).

Rittman and Osburn (1995) described the dilemma of bringing an unsafe nurse into the profession. The preceptor in this study felt that she had facilitated the entrance of a potentially unsafe nurse into the nursing profession when the clinical faculty decided that the student was marginally acceptable and would graduate. However, the ethics of the study are questionable because there was no indication that ethical clearance was obtained for the study.

Hrobsky and Kersbergen (2002) conducted a qualitative study to investigate preceptors' perceptions of unsatisfactory clinical performance and to evaluate how the liaison faculty could improve the process of supporting preceptors when a student's clinical performance is unsatisfactory. In semistructured interviews four preceptors were asked to describe their experiences. The transcripts were analyzed using the NUD*ST software package (SCOLARI, 1995), and the data analysis revealed three primary themes: (a) the hallmarks of poor clinical performance (i.e., "red flags"), (b) the preceptors' feelings, and (c) the liaison faculty's role. Each of these was further subdivided into descriptive themes that the preceptors consistently described (Hrobsky & Kersbergen, 2002).

The preceptors indicated that early in the preceptored clinical experience red flags occurred that they identified as behaviour and attitudes that signal potentially unsatisfactory clinical performance, including students' "not asking questions," "having an unenthusiastic attitude toward nursing," and "demonstrating unsatisfactory skill performance" (Hrobsky & Kersbergen, 2002, p. 551). The preceptors reported feelings of fear, anxiety, and self-doubt as they moved through the process of coping with assessment, reporting, and reaching a resolution in a case of unsatisfactory clinical

performance. For instance, the preceptors' sense of fear and anxiety had to do with knowing that the student would fail if they reported their observation, rather than fear for patient safety (Hrobsky & Kersbergen, 2002). However, it is important for preceptors as well as clinical instructors to realize that not every nursing student will be successful, whether it is in a course taught by a faculty member or in a preceptorship clinical experience (Hrobsky & Kersbergen, 2002; Ilott, 1996; O'Mara, 1997). The preceptors in this study also identified three liaison faculty behaviours that were effective in handling a marginally competent student. These included listening to unsuccessful students, being supportive, and following up after the experience.

Issues for Nursing Preceptors

Stress

Yonge at al. (2002a) studied stress among nursing preceptors by using a descriptive exploratory survey. The purpose of the study was to explore preceptors' perspectives of the nature of stress and the kinds of support needed to make the preceptorship experience valuable. The results of the mailed survey of 295 preceptors revealed that precepting nursing students can be a stressful experience for a great number of preceptors because of increased workloads related to unsuitable students, a lack of time, and insufficient faculty support and guidance. Deficits among students were seen as common sources of preceptor stress. For example, 17 preceptors reported negative reactions to students' personality traits or clinical performance, including laziness, illness, poor English skills, a lack of confidence, or a negative attitude (Yonge et al., 2002a).

Grealish and Carroll (1998) and Yonge, Krahn, Trojan, and Reid (1997a) found that evaluation of skill-deficient students might be a difficult and negative experience for preceptors. Yonge et al. (1997a) further explained that placing skill-deficient students with novice preceptors can be a daunting experience for the preceptor that may threaten the preceptor's self-confidence. Because the preceptor is ultimately responsible for the patient, being paired with a poor student requires extra energy and time to ensure a high standard of nursing care. Thus, the assumption that during their final semester just prior to graduation all students are ready for a preceptorship experience may not be valid. Yonge et al., like Lewis (1990), suggested that borderline students or those with marked deficits in knowledge, motivation, or language should not be placed in a preceptorship program until those deficits have been corrected.

Clinical Evaluation of Students

The preceptorship model assumes that preceptors have the necessary knowledge and skills to supervise and assess students. However, one recurrent issue in the literature is that preceptors have little or no experience in the evaluation role (Coates & Gromley, 1997; Dibert & Goldenberg, 1995; Hrobsky & Kersbergen, 2002; Scanlan et al., 2001; Yonge, Krahn, & Trojan, 1997). For example, Dibert and Goldenberg found that most preceptors had little or no experience in evaluation, and Coates and Gromley reported that the preceptors felt inadequately prepared for the role of assessor. Yet preceptors are expected to provide important information that instructors use to pass judgement on whether or not a student's practice meets the standards set by the school or the profession.

Yonge et al. (1997a) also found a discrepancy between how little preceptors are prepared for the evaluation role and how frequently they are expected to perform this role. In their mailed survey, of the 295 preceptors who responded, 98.3% reported that they had evaluated students, and yet only 28.8% had been taught how to evaluate students. When the authors asked the preceptors how difficult it was for them to evaluate nursing students, 48.5% did not find it difficult, 38.4 % found it somewhat difficult, and only a minority found it difficult. The preceptors also explained why they found some students difficult and others not difficult to evaluate. The comments included "a difficult student made for a difficult assessment" (p. 85). Others reported that failing a student was particularly challenging. For instance, in this study, 16 preceptors (5.4%) had failed difficult or borderline students. Such students, as mentioned earlier, are a challenge to precept and evaluate. In addition, they require extra time and energy (Rittman & Osburn, 1995) and may discourage preceptors from accepting future students, even those whom faculty have described as outstanding (Yonge et al.1997a).

'Failure to Fail' Borderline Students in Clinical or Nonclinical Programs

Many cases of reluctance to award a failing grade and of giving the benefit of the doubt to marginal students (Ilott & Murphy, 1997) have been well documented in the nursing (Allen, 2002; Boley & Whitney, 2003; Duffy, 2004; Duke, 1996; Goldenberg & Waddle, 1990; Lankshear, 1990; Scanlan et al., 2001); occupational therapy (Ilott, 1996; Ilott & Murphy, 1997); social work (Cowburn et al., 2000); teacher (Hawe, 2003); and medical (Dudek, Marks & Regehr, 2005) education literature. In the UK, Allen (2002) reported that most of the 163 preceptors who participated in the study expressed difficulties with the clinical evaluation of students and dealing with those who were

failing. They admitted that they sometimes passed students when, in fact, they should have failed them. Similarly, lecturers (faculty members) in the same study expressed concerns regarding clinical evaluation and failing students. However, the lecturers were clear that this was the responsibility of the preceptors, who had to recognize and accept their status as "gatekeepers to the profession" (p. 77).

In a study conducted on coping strategies among 70 baccalaureate nursing faculty in Canada, Goldenberg and Waddle (1990) identified retaining failing students and failing clinically unsatisfactory students as the second and third highest stressors, respectively. Lankshear (1990) conducted a study in the UK to investigate the attitudes of 30 tutors and clinical educators to assessing the performance of nursing students. The tutors and clinical educators maintained that giving a failing grade not only inevitably results in additional work for the assessor, but also involves having to deal with the resentment of other students and being labelled as a troublemaker. Similarly, Duke's (1996) study of 18 sessional clinical teachers in Australia also revealed that the teachers were so concerned about 'not doing harm' to their students that they were unable to fail them. They worried that failing the student would have an impact on the student's career choices.

Recently in the UK, in a Nursing and Midwifery Council (NMC)-funded study, Duffy (2004) found that mentors (preceptors) were passing students even when they had doubts about their performance. The terms *mentor* and *preceptor* are frequently used interchangeably in the nursing literature (McCarty & Higgins, 2003). In the UK, for instance, mentor is used to denote the role of the nurse, midwife, or health visitor who facilitates learning and supervises and assesses the students in the practice setting

(English National Board of Nursing and Midwifery, 2001). The study, based on interviews with 14 lecturers and 26 mentors, revealed that mentors find it difficult to fail students and are too ready to allow failing students' personal problems to influence their judgments. The findings suggest that borderline students who often have a history of problems in clinical practice are given the benefit of the doubt. Several reasons were cited for passing students when their performance was not up to standard. The mentors did not identify or deal with the students' problems early enough during the clinical placement, and, coupled with the threat of the university's appeals system, this meant that mentors often felt pressured into recording a pass grade that was at odds with their own professional judgment. At times the mentors did not follow procedures in failing a student, which meant that the lecturers could not always support their decisions. Some mentors were reluctant to fail students early in the program with the hope that the students would pick up the necessary skills in future placements. However, this idea of passing students with the hope that they would improve later in the course has implications for patient safety. This finding supports Scanlan et al.'s (2001) observation that clinical teachers are unwilling to fail students early in the nursing program. However, when subsequent mentors are faced with the possibility of failing students late in their program, this presents a personal dilemma for the mentors (Duffy, 2004).

Other mentors in the same study acknowledged giving final-year students the benefit of the doubt because they did not want to jeopardize the students' future, especially when they were so close to finishing their program (Duffy, 2004). Similar findings have been reported in other professional education literature (Hawe, 2003; Ilott & Murphy, 1997). For example, Warren-Piper (as cited in Ilott & Murphy, 1997)

reported a widespread reluctance in the British system to fail students at the end of a program. Some mentors felt that it was not their responsibility to fail students as long as they raised concerns about a student's clinical performance to the lecturers. Others felt uncomfortable "putting pen to paper" (Duffy, 2004, p. 21) because they found the clinical assessment document too complex and full of jargon. This finding concurs with what has been documented in the literature: Most preceptors find the evaluation tool too wordy, confusing, complex, and full of jargon (Allen, 2002; Calman, Watson, Norman, Redfern, & Murrells, 2002; Neary, 2001; Yonge et al., 1997a). Some mentors acknowledged that they were reluctant to fail a student because of their limited experience or confidence as a mentor. Clinical teachers elsewhere have expressed similar concerns (Duke, 1996; Scanlan et al., 2001). Mentors have also revealed that there were times when weak or failing students' personal circumstances influenced their judgments, whereas others saw failing a student as an uncaring practice (Duffy, 2004).

Scanlan et al. (2001) identified several issues inherent in nursing faculty's beliefs and practices that contribute to difficulties in dealing with students who engage in unsafe practice. First, there is a prevailing belief among clinical teachers that students need time to learn and that failing students early in the program does not allow them enough time to succeed. Consequently, clinical teachers are unwilling to fail students, especially early in the program. These observations support findings that have been reported elsewhere in the literature (Ilott & Murphy, 1997). Second, because they may be uncertain about their role, especially in evaluation, novice clinical teachers "may be reluctant to fail students because they are unsure about the legitimacy of their judgments and their ultimate decision about the student's abilities" (Scanlan et al., 2001, p. 26). Third, nursing is

perceived as a caring profession, and therefore failing a student in clinical practice may be seen as an uncaring practice (Scanlan, et al., 2001).

However, Duffy (2004) explained that mentors, or preceptors in this case, need to be prepared to fail students as well as to pass them. She recommended that mentors communicate their concerns about students as early as possible and in writing to faculty members, because failure to do so often means that no action can be taken. Duffy further reminded preceptors of their professional responsibility as gatekeepers to the profession to prevent borderline students who engage in unsafe practice from becoming registered practitioners, thereby protecting the public from incompetent practitioners. In Duffy's study some lecturers expressed concerns about students' assessments and failing, but were clear that the responsibility lay with mentors because they still believed that mentors are the professional gatekeepers and should therefore recognize and accept this status. Duffy contended that preceptors or mentors should be prepared for their role and responsibility in a fail scenario or in the process of managing a situation when a student has failed to meet the expected outcomes for clinical placement. She also recommended further research in this area.

In some instances preceptors interpret awarding a student a failing grade as their own personal failure or incompetence, a fact that is well documented in nursing (Duke, 1996; Lankshear, 1990; Scanlan et al., 2001) and other professional education literature (Hawe, 2003; Ilott & Murphy, 1997). For instance, Ilott and Murphy explored the affective responses to a fail scenario of 30 academic and practice staff in occupational therapy courses in the UK and found a variety of factors that influenced academic and clinical supervisors' decisions to assign a fail grade, such as anxiety, distress, self-doubt,

guilt, regret, and relief. The researchers also concluded that assigning a failing grade is one of the most challenging responsibilities for both academic and practice assessors, especially when there is "co-terminosity of registration to practice and an academic award" (p. 307).

The findings in a field-based project in a preservice primary teacher education program in New Zealand also revealed reluctance to award failing grades (Hawe, 2003) because of, for example, "a belief that students should be allowed to pass if they were in their final year or semester" (p. 376). Failing a student at this late stage was seen as unfair because of the significant personal cost to the student (Hawe, 2003). A failing grade may have a number of devastating effects on all those involved, including the student's withdrawal from the course, termination of the student's career goal (Duffy, 2004; Duke, 1996; Hawe, 2003; Ilott & Murphy, 1997), or potential legal implications (Boley & Whitney, 2003; Diekelmann & McGregory, 2003; Dudek et al., 2005; Smith, McKoy, & Richardson, 2001).

Dudek et al. (2005) conducted a qualitative study in Canada among physicians (clinical supervisors) to explore factors that affect their willingness to report students' poor clinical performance. They identified four major areas of the evaluation process as barriers for supervisors that prevent them from reporting poor performance or failing a trainee: (a) a lack of documentation, (b) a lack of knowledge of what specifically to document, (c) anticipation of an appeal process, and (d) a lack of remediation options. For instance, the participants were concerned about the appeals process because they felt that it would be time consuming, a fact that those who had actually gone through such a process confirmed. Many participants also acknowledged having been threatened with

legal action in the past, which in turn prevented them from failing trainees. Even though many of the participants admitted to feeling threatened, they still believed that the time involved in an appeal was a greater barrier. In fact, one clinical supervisor recalled changing a student's grade because he had been threatened with legal action, a decision he still regretted. Finally, some participants who had undergone an appeal process believed that there was a lack of support from the faculty when an evaluation was challenged and that they would feel more comfortable in failing a student if they had the support of the faculty.

Boley and Whitney (2003) explained that, in the current litigious society, some nursing faculty members fear being sued and are reluctant to fail a student based solely on poor clinical performance. Faculty members also recognize that grading clinical performance is complex and subjective by nature. As a result, they give students the benefit of the doubt by not assigning failing grades even when they should. However, faculty, or preceptors in this case, must recognize that when students display unsafe practice, all those involved may be jeopardizing the safety of patients. It is the preceptor's duty to recognize incompetent nursing practice by applying grading standards and issuing a failing grade if one is warranted (Boley & Whitney, 2003). Faculty and preceptors must ensure that students possess the required knowledge, skills, and competencies to graduate because when they graduate from an accredited program, the degree indicates to society that they have mastered a certain level of skill and expertise and are safe and competent practitioners (Boley & Whitney, 2003). On the other hand, allowing marginally competent students to graduate from a nursing program can damage the reputation or credibility of the program, the institution, and, ultimately, the nursing profession.

Faculty and preceptors must also realize that the courts have overwhelmingly supported faculty decisions regarding grade assignment, as long as the grades were not "arbitrary or capricious" (Boley & Whitney, 2003, p. 198). Therefore, faculty should not fear failing a student solely on the basis of poor clinical performance. However, although the student has the legal right to an appeal, the clinical instructor's responsibility is eased when there has been careful, deliberate, and objective documentation of the student's clinical performance (Smith et al., 2001). Ilott (1996) and Cowburn et al. (2000) affirmed that failure is an expected outcome for a minority of students and that it is inevitable if professional standards are to be maintained. Therefore, some preceptored students will not be able to meet the required standard of practice. Accurate assessments of students' performances are therefore particularly critical when they underpin licensure or registration intended to safeguard professional standards and the public from incompetent and unsafe practitioners (Cowburn et al., 2000; Hrobsky & Kersbergen, 2002).

Although the prevailing discourse in the nursing literature is that it is the faculty member's duty to recognize unsafe nursing practice and assign a failing grade if one is warranted (Boley & Whitney, 2003; Diekelmann & McGregory, 2003; Smith et al., 2001), there has been little research to guide preceptors in difficult or complex learning situations in which nursing students display unsafe practice or fail to meet the clinical objectives (Diekelmann & McGregory, 2003; Hrobsky & Kersbergen, 2002).

Lack of Policies and Guidelines

Scanlan et al. (2001) discussed the issues of justice and fairness in relation to situations that arise when a student repeatedly fails to meet minimum expectations for clinical performance. They addressed the development of policies to deal with such

situations and described how these policies were applied in a case study. The authors noted that there is little information in the literature on managing nursing students with unsafe practices and managing clinical failures. Moeller (1984) reported that clinical supervisors in occupational therapy education, like nurse preceptors, are given few specific guidelines on how to handle problem students. As a result, they are left to develop their own approaches through trial and error, which can be stressful for both the student and the clinical preceptor. Although clinical supervisors or preceptors may be competent as clinicians, they may still be unsure of themselves as educators, especially when they are confronted with problem learners. For instance, they may doubt the appropriateness of their decisions no matter what the outcome (Moeller, 1984).

Clear policies and procedures are essential in guiding the preceptor, student, and faculty member when a student is engaging in unsafe practice. However, Scanlan et al. (2001) found no clear policies or guidelines on clinical evaluation. More specifically, they found unclear criteria for student success, absent or vague definitions of unsuitability for nursing practice, and a lack of specific policies and guidelines for dealing with unsafe students. For example, in a review of the literature in nursing education, Scanlan et al. found that there are few definitions of what constitutes safe or unsafe clinical practice and that only a few universities have clearly defined standards of safe and unsafe clinical practice. Some universities set minimum standards for safe practice, but it is up to the faculty to discriminate whether a student is unsafe. Statements from most of the universities indicated that there were no established criteria for safe or unsafe student practice (Scanlan et al., 2001). Based on information that they gathered from an Internet search and their experiences with students in practice, Scanlan et al.

constructed a definition of unsafe clinical practice: "an occurrence or a pattern of behaviour involving unacceptable risk" (p. 25).

Management of Students with Unsafe Clinical Practices:

A Nursing Perspective

Teeter (2005) suggested an acronym, SUCCESS (See it early; Understand the student's perspective; Clarify the situation with the student; Contract with the student for success; Evaluate the student's progress regularly; Summarize the student's performance; and Sign the summary and look to the future), to use in dealing with students who are failing in the clinical setting. "See it early" means that the clinical instructors, or preceptors in this case, must look for red flags for identifying at-risk students early, such as the student's disappearing from the floor, hesitating when asked questions, frequently asking staff and other students to help, exhibiting unprofessional behaviour, acting distant, being unengaged with learning, and fumbling with skills (Teeter, 2005).

"Understand the student's perspective" means that the preceptor should be sensitive to the student's experience (Teeter, 2005, p. 91). Teeter suggested that preceptors honestly consider how they would have felt in the same situation by asking themselves questions such as, How would you see your role in the situation? Would you have known what to expect? Would you have been aware that there was a problem? What would be important to you at this time? As well, the preceptor should "clarify the situation with the student" (p. 91). Teeter encouraged preceptors to explore the student's perception of the situation; to admit gently, objectively, and honestly their evaluation of the student's performance; and to patiently assist the student in seeing the reality of it. It is important that preceptors provide feedback in private.

Preceptors must also make and sign a written "contract with the student for success" (Teeter, 2005, p. 91) that must be objective, positive, encouraging, and focus on behaviour for success rather than failure. It should include the students' suggestions for resources that that they need to improve. In addition, the contract must include statements that "success is found in a pattern, not one incident" (p. 92) and that all clinical objectives must be met, including setting times for regular evaluation and a timeframe for success. At the end of the meeting, both the preceptor and the student must keep a copy of the contract for future reference, and the preceptor must stress that success will be achieved only if the student meets the criteria listed in the contract. Preceptors are also encouraged to "evaluate students' progress regularly"(p. 91) and to redirect students accordingly, as well as always to refer to the contract, stress the student's strengths or successes rather than weaknesses, and clearly identify areas for improvement. During evaluation meetings, the student must take additional notes as appropriate, and the preceptor must continue to emphasize that success will be achieved only under the circumstances cited in the contract. The preceptor must continue to be kind to and patient with the student (Teeter, 2005).

At the end of the timeframe identified in the contract, the preceptor must summarize the student's performance objectively, include the student's perceptions, and decide whether or not he or she has successfully met the clinical objectives. If so, the preceptor must encourage the student to keep up the good work and stress the importance of maintaining a level of performance to succeed in the remainder of the rotation (Teeter, 2005). If the student has not improved, the preceptor must help the student to understand that this is the case and then counsel the student on the available options. At this stage,

Teeter stressed the importance of allowing the student to save face and find a dignified way to exit. Finally, at the end of the rotation the preceptor and student must "sign the summary" (p. 92) and help the student to look to the future. Teeter contended that the student must leave this process with another formula for success. Whatever option is taken, the plan should represent a positive decision on the part of the student.

A Medical Education Perspective

Vaughn et al. (1998) defined a problem learner or a borderline learner in this case, as "a learner whose academic performance is significantly below performance potential because of a specific affective, cognitive, structural, or interpersonal difficulty" (p. 217). They affirmed that borderline learners are difficult for preceptors to manage but that most physician preceptors, despite their extensive medical knowledge and experience, have had little formal training in educational theory or techniques. Like medicine, teaching is a professional discipline that requires mastery of the body of theoretical knowledge as a prerequisite to practice (Van Hoozer et al., 1997). Therefore it cannot be assumed that, by virtue of their knowledge and expertise, physicians or nurses can automatically function as teachers. As a result, working with a student whose level of performance is questionable can be challenging for the clinical preceptor who lacks specific knowledge of teaching approaches to interact with different kinds of students.

Vaughn et al. (1998) proposed a general problem-solving process, the S-T-P model, through which unique solutions for different problem learners can be developed. The S-T-P model is a three-step process that involves incorporating feedback into problem solving: (a) S—specifying the problem, (b) T—identifying the desired target state, and (c) P—describing the procedure, plan, or path to move from S to T. Moreover,

Vaughn et al. offer suggestions for evaluating students with unsafe practices, including placing greater emphasis on peer and self-evaluation, gaining insights into teaching and implementing the S-T-P model, and using role play. They further contended that consideration of the problem learner leads to evaluative, curricular, and organizational changes in residency programs and medical schools.

Similarly, Lucas and Stallworth (2003) described problem learners as those who "perform significantly below their potential due to specific difficulties" (p. 554). They acknowledged the fact that it is very difficult for clinical teachers to give feedback and direction to such learners. These authors, like Vaughn et al. (1998), categorized borderline learners as those with affective, cognitive, structural, and/or interpersonal difficulties. Lucas and Stallworth presented a mnemonic, TIPS (Type and specify the ineffective behaviours; Identify the category of difficulty that the learner is experiencing; Perception versus reality feedback; and Strategies for treatment and follow-up), to assist preceptors in dealing with and giving feedback to learners with specific difficulties. They concurred with Vaughn et al. that the S-T-P model is an excellent approach to working with students who display unsafe practices and that it offers some suggestions on how to help them. Lucas and Stallworth adapted this model to include more information for the clinical preceptor on feedback and strategies for follow-up in dealing with problem learners.

Langlois and Thach (2000a) suggested that, just as in medicine, approaches to teaching can be divided into primary, secondary, and tertiary prevention. Their view is that many potentially difficult situations in clinical teaching can be prevented by using the educational techniques of setting expectations, giving timely and constructive

feedback, and providing thoughtful, ongoing evaluation (primary prevention). They explained that other issues can be detected early by being alert for and paying attention to clues (red flags) that may indicate a subtle or developing issue (secondary prevention). However, they also acknowledged that there are times, despite best efforts to prevent such situations, when a problem may occur that may require careful management and assistance from the faculty or other resources (tertiary prevention; Langlois & Thach, 2000a).

Langlois and Thach (2000b) also offered some tips on managing difficult learning situations. They suggested the use of a SOAP (Subjective, Objective, Assessment, and Plan) format as a strategy for diagnosing and managing a difficult learning situation. They claimed that, just as the SOAP format helps health care professionals to organize and record their clinical notes, it can also help preceptors to organize and manage difficult learning situations. They explained that the SOAP format, as adapted from Quirk (as cited in Langlois & Thach, 2000b), allows one to gather basic data, make objective assessments, and develop a differential diagnosis and plan of action.

A Dental Education Perspective

Hendricson and Kleffner (2002) developed a model with an acronym, P-E-T (Prime, Partition, and Praise; Empathy; Teach), as a reminder for teachers, or preceptors in this case, of strategies that are particularly useful in managing challenging or struggling students. *Prime* means that the preceptor should provide prompts to students just before they perform a task by going through key elements and alerting them to potential problems. *Partition* implies that the preceptor should allow students to build from past success by assigning students manageable tasks early in the rotation and then

gradually expanding the scope of responsibilities. Preceptors should *praise* students whenever they have successfully accomplished a task and offer words of encouragement when they encounter problems. Preceptors are also encouraged to *empathize* with students by sharing their experiences as students, including stories about errors that they made and how they managed to improve their performance. Preceptors must let their students know that they acknowledge and understand that professional training is a developmental continuum and that mistakes will occur, especially early in the learning experience (Hendricson & Kleffner, 2002). Last, the preceptor should take a more proactive coaching role by *teaching* and guiding students in patient care activities through using demonstrations, cues, prompting questions, and constructive feedback (Hendricson & Kleffner, 2002). Hagler and Macfaren (1991) viewed coaching as an integral aspect of clinical education and explained that although coaches may occasionally give direct, specific suggestions to impart information to students, more often they will provide support and a certain degree of flexibility. As well, coaches are encouraging, provide challenges, encourage risk taking, and therefore will except and allow mistakes. Coaching refines skills and skill improvements, which in turn enhances confidence (Hagler & Macfaren, 1991).

Hendrickson and Kleffner (2002) contended that teachers, or preceptors in this case, should focus more on helping students learn, rather than evaluating performance. They advised preceptors to assist students in identifying skills that need to be improved and that students want to pursue, and then to create opportunities for students to work on these skills and interests. Like other authors (Langlois & Thach, 2000a; Lucas & Stallworth, 2003; Moeller, 1984), Hendricson and Kleffner suggested that preceptors

should give immediate, corrective feedback during and after performance or when errors occur and should always encourage students' self-evaluation of the task.

An Occupational Therapy Education Perspective

Moeller (1984) identified the following strategies for managing students with unsafe practice. Like Langlois and Thach (2000a), Moeller suggested that preceptors (a) set objectives and minimal standards, (b) thoroughly orient students to the clinical setting, (c) share expectations with students prior to the experience, (d) engage in continuous monitoring and documentation of any identified problems, (e) provide constructive feedback, (f) contact the clinical tutor whenever necessary for further information, and (g) engage in joint decision making on the proper course of action. Moeller explained that if there is no improvement in the student's performance by midterm, the preceptor must initiate a joint meeting with the student, preceptor, and clinical instructor to decide whether the student should continue or discontinue the rotation. If the student is allowed to continue, then a written contract needs to be agreed upon and signed by all. Finally, a follow-up meeting on the joint contract plan should be held and a decision made jointly (by the instructor and preceptor) on either passing or failing the student.

A Speech-Language Pathology and Audiology Education Perspective

Shapiro et al. (2002) presented the findings of a national survey of 91 master's degree–awarding programs that explored the prevalence, profiles, and documented impact of borderline students on professional graduate training programs in speech-language pathology and audiology in the USA. The findings reveal three profiles of borderline students that include (a) academic characteristics—acquiring or applying

knowledge within the academic setting, (b) clinical characteristics—applying knowledge within the clinical context and global clinical deficits, and (c) nondesignated characteristics—negative personal characteristics and deficient professional skills/behaviour (Shapiro et al., 2002).

Shapiro et al. (2002) identified four types of intervention strategies in the study: (a) additional or modified practicum experiences, (b) additional or modified supervision (supervisor/supervisee experiences), (c) academic/remedial intervention, and (d) noninstructional intervention. Modified practicum experiences, which help to improve the skills of students as providers of clinical services, include "working directly with a master clinician, reducing clinical demands, postponing or repeating a practicum experience, and carefully selecting clinical assignments to coordinate a clinician's skills with a client's needs, thereby reducing the demands upon a student" (p. 431). Modified supervision experiences improve the instructional prominence of the supervisee/ supervisor interaction through establishing goals and contracts with the student clinician, providing more direction in clinical training, increasing the number of supervisory conferences and the degree of supervisory feedback, and engaging multiple supervisors with a student (Shapiro et al., 2002).

The results of Shapiro et al.'s (2002) national survey indicate that, of the three borderline student scenarios, students whose academic work is within acceptable limits but who exhibit poor clinical performance are the most common, whereas those with barely or below satisfactory academic work and clinical work within acceptable limits are less common. Those with both academic and clinical work barely or below satisfactory are least common (Shapiro et al., 2002). Overall, the findings reveal that the degree of

impact on the program is less when a borderline student has academic or clinical strengths and is greater when a student has neither of the two.

Similarly, Hunt et al. (1989) conducted a survey in the USA to examine the prevalence and degree of difficulty of problem students in medical education. Their findings reveal that clinical teachers are more likely to encounter learners with interpersonal or cognitive problems. However, bright students with poor interpersonal skills and those who are excessively shy or nonassertive are the most difficult to manage.

A Physical Therapy Education Perspective

Hayes, Huber, Rogers, and Sanders (1999) conducted a retrospective, descriptive, and qualitative study in the USA to examine the behaviour and characteristics of physical therapy students that can alert clinical instructors to unsafe and ineffective clinical performance. The clinical educators identified a total of 134 behaviours as red flags that fell into three categories: inadequate knowledge and skills (cognitive behaviours), poor communication, and unprofessional behaviour (noncognitive behaviours). The category of inadequate knowledge and skills was the largest, comprising 43.3% of the identified behaviours. This category included five subcategories: (a) inability to recall information, (b) inability to perform a skill, (c) inefficiency in task completion, (d) poor problem solving, and (e) unsafe judgments or actions. Out of 134 behaviours, 37 (27.6%) fell into the category of poor communication, which is related primarily to inappropriate nonverbal behaviour, inappropriate interaction with patients and colleagues, and inappropriate response to feedback. The unprofessional behaviour category, which included 29.1% of the identified behaviours, included work ethic, willingness to accept

responsibility, commitment to learning, and recognition of boundaries (Hayes et al., 1999).

Hayes et al.'s (1999) findings further indicate that, although the clinical educators noticed and valued noncognitive behaviours, they addressed cognitive behaviours more often with students. For instance, noncognitive behaviours comprised 56.7% of the behaviours that alerted clinical educators to unsafe and ineffective performance, but they accounted for only 35% of the behaviours associated with negative outcomes. The authors recommended that clinical educators identify both noncognitive and unacceptable cognitive behaviours as early as possible in clinical experiences and address their concerns with students.

An Interdisciplinary Perspective

Verma and Paterson (1998) described an interdisciplinary workshop that highlighted the problems encountered with borderline students. It was intended to explore mechanisms to minimize the legal, emotional, and bureaucratic ramifications of failing such students and to facilitate the decision-making process in dealing with these situations (p. 162). The authors acknowledged that borderline students pose the greatest dilemma to educators, especially when the students are about to graduate. Verma and Paterson contend that many preceptors are not specifically trained to deal with this type of situation and explained that "the problem occurs from the identification or late identification of these students, poor or inadequate documentation of the problems, failure to address the problems with the planned interventions, and failure to evaluate the results of remedial interventions" (p. 162).

Verma and Paterson's (1998) main suggestions for dealing with borderline students including identifying them early, vigilantly collecting data and documenting, developing an educational contract, designing a remedial intervention, reevaluating the intervention, evaluating clearly and concisely, making a clear decision to pass or fail, discussing the decision with the student, and remembering to ask, "Are there 'extenuating circumstances'? Are there legal issues?" (p. 165).

Challenges such as these remind us, as professionals, of the importance of the supervisory process and other aspects of clinical teaching. Thus, the need for proper training for preceptors is more evident when they encounter students who display unsafe practices. Vaughn et al. (1998) asserted that preceptors from different disciplines may differ in their perceptions of how difficult it is to manage different problem-learner types. For example, in a workshop that they conducted with emergency-medicine physicians, they found that there were greater concerns about problem learners who showed a lack of interest and were not motivated. In their study of over 500 clerkship directors, Hunt et al. (1989) found that internists were more likely than pediatricians, obstetricians and gynecologists, and psychiatrists to see students "who didn't measure up" (p. 17) intellectually as the most problematic. However, psychiatrists in that study considered students with psychiatric problems problematic more frequently than did preceptors from other disciplines, pediatricians reported the highest occurrence of problem learning in those who challenge everything, and obstetricians and gynecologists reported a low frequency of problem learners in general. Vaughn et al. concluded that solutions to managing students with unsafe practices cannot be generally prescribed, but instead should be unique to the school, hospital, discipline, or environment.

Policy on Safe Student Practice during Clinical Placements

The goal of the nursing profession is to provide safe, competent, and ethical nursing care to the public. Thus, nursing students, like RNs, (a) are expected to provide the highest quality of care for their clients, (b) must ensure that they maintain an acceptable level of personal health and well-being, (c) must practice within their own level of competence, and (d) must admit mistakes and take all necessary actions to prevent or minimize harm that arises from an adverse event (CNA, 2002; Provincial Association of Registered Nurses, 1999). Therefore, the university nursing faculty in this study has an academic, legal, and ethical responsibility to prepare graduates who are competent to protect the public from unsafe nursing practice. For instance, the university's GFC (2003) policy manual on practicum placement gives deans the authority to protect the public interest by allowing them to withdraw a student from or deny his or her placement in a practicum. The policy also serves as a guideline for decision making when students are not or may not be capable of safe, ethical, and competent professional practice. It is within this context that a student whose practice or behaviour is found to threaten or have the potential to threaten the safety of a client or other health care provider can be disciplined or withdrawn from the clinical placement and receive a failing grade for the course.

It is imperative, therefore, that proper definitions of safe and unsafe clinical practice be established and communicated to students as well as to preceptors prior to the beginning of the preceptorship experience. These are crucial in communicating, particularly to students, the parameters under which they must function (Scanlan et al., 2001).

Regulatory Mechanisms for Evaluating Safe Practice

Maintaining client safety is the key principle in clinical practice. To ensure safe client care and ethical, professional practice, nursing students must provide care within the guidelines of the provincial association's Nursing Practice Standards, the CNA (2002) Code of Ethics for Registered Nurses, the GFC's (2003) Code of Student Behaviour, and academic standards and policies listed in the course outline (Faculty of Nursing, 2004a). In addition, students are expected to practice within the rules and regulations of the health care agency and function at the expected clinical level as stated in the course objectives and clinical evaluation forms. For example, Section 30.3.3(1) of the Code of Student Behaviour states, "A student enrolled in Professional Programs is bound by and shall comply with the Professional Code of Ethics governing that profession and the practice of its discipline" (p. 8). Section 30.3.3 (2) of the Code states:

> A student enrolled in a Professional Program who contravenes the professional Code of Ethics governing the profession and the practice of its discipline commits an offence under this Code when, at the time of the alleged offence, the Student is involved in a Practicum Placement related to a course of study in a Professional Program. (p. 8)

The CNA (2002) Code of Ethics sets out the ethical standard of behaviour expected of RNs in Canada. It provides guidance for decision making on ethical matters, and serves as a means for self-evaluation and self-reflection regarding ethical nursing practice (Alberta Association of Registered Nurses [AARN], 1999). Nursing students, like RNs, are expected to comply with the CNA's (2002) Code of Ethics for RNs. They must practice with honesty, integrity, and respect; report unskilled practice or professional misconduct to an appropriate person, agency, or professional body; act as an advocate to protect and promote a client's right to autonomy, respect, privacy, dignity,

and access to information; and assume responsibility for ensuring that their relationships with clients are therapeutic and professional. In addition, it is the responsibility of all nursing students to understand the Provincial Association Nursing Practice Standards and apply them to their nursing practice, regardless of their areas of practice or designated roles. This is important because these standards are prerequisites for the promotion of safe, competent, and ethical nursing practice (AARN, 1999).

According to the academic standards and policies of the Faculty of Nursing (2004a), in clinical practicum nursing students are expected, but not limited to, (a) adhering to the Provincial Association Standards of Nursing Practice, (b) adhering to the university's Code of Student Behaviour (GFC, 2003), (c) adhering to the dress code and policies of the agency in which they are practicing, (d) being self-directed in acquiring and understanding the knowledge that they need to practice competently in the clinical setting, and (e) asking for guidance whenever necessary (Faculty of Nursing, 2004a, p. 7). To pass the course, students must (a) demonstrate safe ethical nursing practice, (b) adhere to the Nursing Practice Standards, (c) display professional behaviour, (d) complete 340 hours of clinical practice, and (e) achieve an acceptable standard rating for each of the items on the clinical evaluation form (Appendix B). Therefore, all students are urged to become familiar with the principles of safe practice and professional conduct and are expected to perform in accordance with these requirements.

Last, according to the course evaluation criteria (Faculty of Nursing, 2004a), the following will result in immediate failure of the course: (a) unsafe behaviour or demonstrated potential for causing harm, (b) lack of progress in clinical competence, (c) lack of improvement in response to feedback from the preceptor and/or tutor, and

(d) ineffective self-evaluation to improve clinical behaviour. Therefore, nursing faculty, clinical instructors, and preceptors have the responsibility to identify unsafe, unethical, or unprofessional student conduct and performance in the academic and clinical areas and to take immediate corrective actions.

Summary

Preceptors have often described precepting senior students as a rewarding or gratifying experience. However, dealing with students whose level of practice is borderline or unsafe may make precepting a tedious, complex, and challenging experience for the preceptor. Unsafe students are those whose clinical performance is significantly below standard performance because of a specific affective, cognitive, structural, or interpersonal difficulty. Unsafe clinical practice includes behaviour that reflects a lack of knowledge, skill, or clinical judgment or any unprofessional or unethical conduct by a student that could jeopardize the client's safety, health, or life. The goal of nursing is to provide safe, competent, and ethical nursing care to the public, and nursing students are expected to provide the highest quality of care for their clients by practicing within the ethical code of nursing, the professional standards, and the academic standards and policies listed in the course outline (Faculty of Nursing, 2004a).

The main theme identified from the literature review is that students whose level of performance is questionable or unsafe are difficult to precept. Some strategies for managing such students have been suggested, mainly in the nonnursing professional education literature. However, it is also acknowledged that preceptors from different disciplines may differ in their perceptions of how difficult it is to manage different problem-learner types. Thus, solutions to students' displaying unsafe practices are not

necessarily generalizable or prescriptive but may be unique to a particular student, school, hospital, discipline, or environment. The reviewed literature in nursing education has revealed that there is still little known about how preceptors teach or manage students who engage in unsafe practices. Therefore there is a need for nurse educators and researchers to conduct studies to determine the strategies that preceptors can use to effectively teach and manage students whose level of performance is borderline or unsafe. Thus, the research question is, "What is the process of dealing with a student whose level of performance is marginal or unsafe, unethical, or unprofessional during preceptorship?"

CHAPTER 3:

METHODS

This section outlines the method that I employed to conduct this study. Congruent with the grounded theory approach, theoretical sampling and constant comparative analysis were central to this study. The ethical considerations associated with this research and the steps that I took to ensure rigour and trustworthiness are outlined.

Study Design

I used grounded theory to explore how nursing preceptors manage or deal with students whose level of performance is borderline or unsafe. Grounded theory is a qualitative method that acquires its name from the practice of generating theory from research that is 'grounded' in the data. The aim of the grounded theory approach is to develop explanatory theory about common social patterns. As Crooks (2001) explained, "Grounded theory gives us a picture of what people do, what their prime concerns are, and how they deal with these concerns" (p. 25). The reason for using grounded theory for this study is that there is very little information in the literature on how preceptors teach or manage nursing students with unsafe practices. Many authors suggested that grounded theory is especially suited for studying areas in which there has been little research on a phenomenon or where there is a need to gain a new perspective in familiar areas of research (Burns & Grove, 1995; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

The foundations of grounded theory are embedded in symbolic interactionism (Blumer, 1969; Burns & Grove, 1995; Cutcliffe, 2000; McCann & Clark, 2003a), which explores the processes of interaction between people's social roles and behaviour (McCann & Clark, 2003a). Interaction is symbolic because these processes use symbols,

words, interpretations, gestures, and language. Symbolic interactionists contend that people construct their realities from the symbols around them through interaction; therefore, individuals are active participants in creating meaning in a situation (Cutcliffe, 2000; Morse, 1995). Meanings are created by experience, shared by groups, and communicated to new members through socialization processes. Although these experiences are unique to each individual, it is recognized that individuals who share common circumstances, such as preceptors, experience common perceptions and thoughts and display common behaviours, which is the essence of grounded theory (Bogdan & Biklen, 1998; McCann & Clark, 2003a). As the underlying methodology of grounded theory, symbolic interactionism permitted the researcher to develop an understanding of the meanings and shared definitions that preceptors create from their experiences of working with students with unsafe practices.

Blumer (1969) generated three main principles or premises that guide the symbolic interactionist approach. The first principle is that human beings, individually and collectively, act towards things based on the meanings that these things have for them. These things may include objects, other people, or situations (Eaves, 2001). This implies that people do not respond directly to these things. Instead, they act on the basis of the meaning that they derive from symbolic interaction; that is, meanings inform and guide their actions.

The second principle is that meaning arises out of one's social interactions with others (Blumer, 1969). Symbolic interactionism focuses on ongoing interaction and how such interactions may contribute to the individual's personal beliefs, attitudes, and behaviour. While recognizing the unique views of individuals, symbolic interactionism

acknowledges that these views respond to the socialization process within the individual's particular environment (Byrne & Heyman, 1997).

Third, according to Blumer (1969), meanings can be modified over time as a result of experience and interpretive processes. Meaning is not fixed, but always in process, and thus individuals can select, suspend, and even transform the meanings that they hold in light of changing situations and circumstances. Preceptors therefore both create and are influenced by a culture which defines their role as preceptors, as well as their behaviour and attitudes toward students (Byrne & Heyman, 1997).

In the context of the current study, the way that a preceptor responds to a student who displays unsafe practice may be quite different from how he or she will respond in the future. For example, the more experience that a preceptor gains through interactions with students and experienced colleagues, the more the preceptor's view and meaning toward such students may evolve. As well, the experience with such a student may even persuade a preceptor to decline students in the future.

Setting and Population

I conducted this study in selected acute care practice settings, and I interviewed the participants, who I initially accessed through the respective hospitals, at a mutually agreed upon place and time. The population for the study was comprised of preceptors for final-year undergraduate and after-degree nursing students in a large university in western Canada.

Sample

Description of the Final Practicum Course

The practicum course in question is a senior clinical course offered to students in their final term of the Bachelor of Science in Nursing (BScN) Collaborative Program, After-Degree Program, and Post-RN Program. It is a nine-credit course that students complete over a period of 10 weeks and involves 340 hours of comprehensive exposure to nursing practice in an area of special interest to the nursing student. This experience, continuous over a block of time, could occur in a particular setting with clients with either stable and predictable or unstable and unpredictable disruptions of health. Students are expected to practice with increasing independence under the supervision of an RN or other designated preceptor (Faculty of Nursing, 2004a).

Required Learning Experiences

During the clinical experience students spend time with clients and carry out the work of nurses, and they are expected to work the same clinical hours that their preceptors do. During the first week of clinical practice students are expected to share their learning objectives with their preceptor(s) and faculty member. Preceptors are expected to complete midterm (at the completion of 170 hours) and final (at the completion of 340 hours) evaluations of the students' progress in meeting the practicum course objectives.

Evaluation of the Course

To pass the practicum, students must demonstrate safe, ethical nursing practice and professional behaviour, among other requirements. Demonstration of unsafe behaviour or the potential to cause harm will result in immediate failure of the course.

Further information on the practicum course evaluation is discussed later in this chapter under the section Policy on Safe Student Practice in Clinical Placement.

A sample of preceptors associated with the final fourth-year clinical practicum provided the sample for the study. Consistent with grounded theory research, the sample consisted of 22 participants (Cresswell, 1998; Morse, 2000; Polit & Beck, 2004), the majority of whom were female, and two were male. The participants' ages ranged from 26.5 to 62 years. The ages of about three quarters of the preceptors ranged between 40 and 60 years. Almost two thirds of the preceptors who participated in this study had a diploma level of preparation, and slightly more than one third were prepared at the baccalaureate level. About half of the preceptors worked on surgery units, less than one third on psychiatric and medical units, and one on a burn unit.

Theoretical sampling is central to grounded theory method. Theoretical sampling refers to the method of selecting sites and/or participants based on their theoretical relevance rather than predetermination (Glaser, 1978). Beyond the decisions concerning the initial collection of data, additional sites and participants are determined as the researcher discovers codes and tries to saturate them by theoretical sampling in comparison groups. This means that the data analysis guides the researcher to the next sources of data collection and interview style (Strauss & Corbin, 1990) on the basis of the evolving relevant theoretical concepts. The basic question in theoretical sampling is, "What groups or subgroups does one turn to next in data collection, and for what theoretical purpose?"(Glaser & Holton, 2004, p.10). This means that once I had collected and analyzed the initial data, I based further decisions about the participants, the sample

size, and the type of data to be collected on the emergent categories and theory (Glaser, 1978).

The preceptors whom I chose to participate in the study were those who had experience in precepting students whose level of practice was deemed unsafe. At the beginning of the study I used purposive sampling, or sampling according to certain predetermined criteria (Patton, 1990). The main criteria for inclusion were previous knowledge and experiences in dealing with students who engaged in unsafe practices.

As the data emerged, however, a selected number of preceptors with no direct experience of such students were also asked to participate to allow me to search for 'negative cases' (people who may provide contrasts in experience to that of other participants; Strauss & Corbin, 1990). Negative case analysis is one of the key components of theoretical sampling. As hypotheses are generated, the researcher carefully examines participants who appear to be the exceptions in the study or whose experiences would not confirm an emerging hypothesis or disprove the emerging theory. Negative case analysis helps to refine hypotheses or to elicit variation and to expand the developing theory (Morse, 1991). In qualitative research negative case analysis is also an important technique for enhancing the credibility of study findings. To increase credibility, the researcher must explore these cases thoroughly enough to understand the differences and incorporate them into the model, which provides the flexibility and variation needed to strengthen a grounded theory (Strauss & Corbin, 1998).

Thus, I was able to access key participants and sample relevant data that shed light on and confirmed or denied the emerging hypotheses and concepts (Schreiber, 2001). In fact, at the beginning of the interviews I asked all of the preceptors if they had

had any experience in precepting a student with unsafe practice. It is interesting that some of them initially indicated that they had not had such an encounter; however, during the process of the interview they later realized that they had actually had students at some point in the past with unsafe practices such as medication errors, attitude problems, or sloppy work that they believed at the time were merely minor problems.

To ensure confidentiality, I did not have access to the names of the students, but only to the identities of the preceptors who had worked with these students. Thereafter the data collection was directed by theoretical sampling, which continued until I achieved theoretical saturation. Saturation in grounded theory occurs "when no new data emerges relevant to particular categories and subcategories, categories have conceptual density, and all variations in categories can be explained" (McCann & Clark, 2003a, p. 11). Saturation occurred when I discovered no new data from which to develop the properties of the categories.

Recruitment of Participants

I recruited participants by using several methods. I gave the preceptors in the final practicum within the region information regarding the recruitment of volunteers to participate in the study by sending written information letters to each of the clinical areas within the region (Appendix C). I also approached the clinical educators and/or preceptors within the region during preceptorship workshops that the Faculty of Nursing at the university offered and followed this up with a telephone call if necessary.

Initially, it was difficult to find volunteers for the study. About a month after I had received ethical approval from both the Ethics Review Committee and the regional heath authority, I confirmed the first three volunteers, and a month later I managed to recruit

three more volunteers. Thereafter, with assistance from my thesis supervisor, a committee member, and unit managers, I was able to obtain the remainder of the participants.

Ethical Considerations

I sought permission in writing from the Associate Dean of the Undergraduate Nursing Program in the Faculty of Nursing at the university to conduct a study and requested ethical approval from the Health Research Ethics Board. I used several measures to ensure the preceptors' confidentiality. I gave each participant a verbal and written explanation of the purpose and potential benefits of the study (Appendix D) and informed them that their participation in the study was voluntary. Agreement to participate in an interview indicated their consent to participate in the study. In addition, I asked the participants to sign a written consent form (Appendix E) prior to being interviewed and audiotaped. To ensure confidentiality, I did not use the names of the participants on the audiotape recordings, written transcripts, or field notes; instead, I randomly assigned them code numbers. All transcriptions and other important data will be kept in a locked cabinet for five years. In addition, because of the sensitivity of this topic, the consent forms have been stored separately from the interview data.

Data-Collection Procedures

The data collection and analysis were consistent with the grounded theory method (Glaser, 1978; Glaser & Strauss, 1967). A combination of data-collection methods is characteristic of grounded theory (Charmaz, 2000). In this study I collected data mainly through one-to-one semistructured interviews with preceptors, as well as through a review of official documents such as guidelines for preceptorship to supplement the data whenever necessary. In addition, I kept a journal of personal reflections on the field work

because I assumed that a mixed approach to data collection would provide richer data than a single approach would.

Interviews play a central role in the data collection in a grounded theory study (Cresswell, 1998; Schreiber, 2001). The interviews (a) provided richer and more complex data, (b) presented an opportunity to clarify questions if they are ambiguous or misunderstood, (c) provided an opportunity for me as the interviewer to observe the participants' responses, (d) allowed the participants to discuss their thoughts and feelings on precepting students with unsafe practices, and (e) gave me the opportunity to ask a range of in-depth questions and the participants to narrate their experiences in the phenomenon under study.

As stated above, the interviews were semistructured and evolved in content based on the participants' responses. The decision to use interviews for this study was influenced by the nature of the research question, the aims of the study, and the chosen method. Because the study was inductive in nature and sought to identify strategies that preceptors use to deal with students who engage in unsafe practices, I considered conducting in-depth semistructured interviews the best approach to obtain rich data.

Second, Mayan (2001) explained that semistructured interviews are used "when the researcher knows something about the area of interest, for example, from the literature review, but not enough to know the answers to the questions that are asked" (p. 15). Because there is very little information in the literature on how preceptors manage nursing students with unsafe practices, the semistructured interviews gave me the opportunity to ask a range of in-depth, open-ended questions and allowed the participants

to describe their experiences and express their opinions, concerns, and feelings (Patton, 1990) on the phenomenon under study.

To saturate the data, however, semistructured interviews require a relatively large sample of participants compared to other data-collection strategies (Mayan, 2001; Morse & Field, 1995). This strategy (a) is also time consuming and resource intensive compared to questionnaires (especially if the sample is spread over a large area); (b) may result in a loss of standardization and comparability because probes make each interview slightly different; and (c) increases the chance of interviewer bias compared to structured interviews. Although the semistructured interviews allowed me to collect data from individual participants through a set of open-ended questions that I asked in a specific order (Mayan, 2001), I took care throughout the interview process to avoid imposing too much structure on the interview, which might have limited the amount and quality of data (McCann & Clark, 2003c; Schreiber, 2001; Strauss & Corbin, 1990).

I conducted the interviews in a private room and tape-recorded them; they lasted between 20 and 50 minutes. Prior to the taped interviews, I obtained demographic data (Appendix F) from all of the participants. During the interview I used an interview guide with open-ended questions (Appendix G) to help the participants to narrate their experiences with nursing students with unsafe practices. For example, "Please tell me what it was like to be a preceptor dealing with a student who engages in unsafe practices." I also asked subquestions to clarify statements, ideas, thoughts, and feelings and to gain a fuller understanding of the phenomenon under study. Initially, it was not possible for me to determine the specific sample size and number of interviews that I

would conduct; however, once the categories became saturated and I was obtaining no new data, I stopped the interviews.

I compiled the questions in the interview guide from the literature, and my thesis committee members, who are experts in the area of preceptorship, checked the content validity of the questions. As well, five preceptors reviewed the semistructured interview guide. Thereafter, I made changes based on their feedback. To assess my interviewing skills, my thesis supervisor reviewed the first few tape-recorded interview transcripts. In addition, for the sake of truthfulness or accuracy, I gave the participants a chance to review their transcripts to ensure that I had adequately reflected their perspectives. A few made some additions or corrections, but otherwise the majority felt that they were acceptable.

Data Organization

Immediately after each interview, I transcribed and analyzed the tape-recorded interviews, handwritten field notes, and memos and read and reread them before coding until I became thoroughly familiar with the data (Glaser, 1978; McCann & Clark, 2003c).

Data Analysis

I analyzed the data using constant comparative analysis as described by Glaser and Strauss (1967) and Glaser (1978). The constant comparative method enables the generation of theory through systematic coding and analytic procedures. The process involves going back and forth from one case or transcript to another and from one category to another to search for relationships between concepts. First, incidents are compared to incidents to establish the underlying uniformity or similarities and the varying conditions. The uniformity and conditions become generated concepts and

hypotheses (Glaser & Holton, 2004). Second, concepts are compared to more incidents to generate new theoretical properties of the concept and more hypotheses. Finally, concepts are compared to concepts to establish the best fit of many choices of concepts to a set of indicators, the conceptual levels between the concepts that refer to the same set of indicators, and the integration into hypotheses between the concepts, which then becomes the theory (Glaser & Holton, 2004). The main purpose of constant comparison is to generate or build a dense theory, with categories that are conceptual and abstract and have properties and dimension (Cutcliff, 2000; Glaser & Strauss, 1967).

The goal of data analysis in the grounded theory approach is to generate a core variable to illuminate the social psychological process that is occurring and, in this particular instance, to explicate the process that occurs in precepting an unsafe student (Glaser, 1978; Streubert & Carpenter, 1999). The core variable is the category that (a) is central and is related to as many other categories and their properties as possible, (b) recurs frequently in the data, and (c) accounts for most of the variation (Glaser, 1978; Streubert & Carpenter, 1999). Thus, as I analyzed the data, I searched for a core variable that would serve as the foundational concept for theory generation. I began the data analysis simultaneously with data collection and achieved it through the process of coding. Coding occurred at three levels: open coding, theoretical coding, and selective coding. Coding is the process of analyzing data (i.e., naming or labelling concepts, sorting into categories) by asking questions about the data and comparing the events. I labelled similar events and grouped them to form categories.

The coding process began with open coding (level 1 coding). The intent of coding was to conceptualize the data by analyzing them and identifying patterns or events. The

first step in conceptualizing was to assign patterns in the data conceptual labels (McCann & Clark, 2003c). The first level of analysis guided me in determining in which direction to take the study by utilizing theoretical sampling before selecting and focusing on a specific problem (Glaser, 1978).

Open Coding

During the process of open coding I carefully examined and compared each piece of data with other data (Glaser, 1978). Open coding is the process of 'fracturing' or breaking down the data into discrete parts to identify and name relevant categories (McCann & Clark, 2003a). I examined the data line by line to conceptualize them and identify patterns or events and then selected and labelled as codes the words or phrases that contained a single unit of meaning (Schreiber, 2001). Thus, I established substantive codes based on the participants' descriptions of their experiences of dealing with students who engage in unsafe practice and on the literature review that I completed.

The codes at this level are referred to as *substantive* because they organize or codify the substances of the data and often use the participants' own words (Stern, 1980). Substantive codes are classified into two categories (Glaser, 1978): (a) those that are derived directly from the participants' own words (*in vivo* words); for example, "poor skills," "difficult," "frustrating," "time consuming," "stressful," "extra workload," "unmotivated students," "sloppiness," "cockiness," "overconfidence," "being watchful," "constant observation," and "medication errors"; and (b) those implied codes that the researcher constructs based on concepts obtained from the data, such as "poor work ethic," "unprofessional behaviour," "inappropriate interpersonal skills," "lack of organizational skills," "dishonesty," "lack of knowledge and skills," self-doubt," "sense

of fear," "preceptor's role," "instructor's role" "preceptor's recommendations," "teaching/guiding strategies," and "evaluation process" (Glaser, 1978; Strauss & Corbin, 1990; Streubert & Carpenter, 1999). According to Glaser, substantive codes "conceptualize the empirical substance of an area of research" (p. 55) and are different from theoretical codes, which "conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory" (p. 55). Once I created them, I compared the codes with other categories to determine how they connected or clustered (Myrick, 1998; Stern, 1980). During this process I attempted to discover as many categories as possible and compared them with new indicators to uncover characteristics and relationships (Streubert & Carpenter, 1999). As the data collection progressed, I discarded codes that lacked foundation in the data and added more relevant codes (Glaser, 1978; Streubert & Carpenter, 1999).

The process of open coding was guided by a number of questions, including the following: What is going on here with regard to the process of precepting a student with unsafe practice? What do these data indicate with regard to this process? What category does this incident indicate? What are the basic psychological processes or social structural processes that preceptors use in responding to a nursing student who engages in unsafe practices? (Glaser, 1978, 1992). These questions and many more that "arise as the theoretical codes emerge keep the substantive directions in tractable focus as they force the generation of a core category" (Glaser, 1978, p. 57).

Theoretical Coding

As the number of substantive codes accumulated, I turned to level 2 coding analysis, which involves theoretical coding, a process in which the data are ordered and

the interrelation of the substantive categories is determined. The goal of second-level coding, according to Glaser (1978), is the generation of "an emergent set of categories and their properties which fit, work, and are relevant for integrating into a theory" (p. 56). During the theoretical coding I constantly compared new data with the emerging clusters of data and assigned the data to clusters or categories according to obvious fit. This process enabled me to determine the particular category that was appropriate for the grouping of similar substantive codes. I then compared each category with every other category to ensure that the categories were mutually exclusive (Streubert & Carpenter, 1999). During second-level coding I collapsed the substantive codes that I had developed in open coding into categories or higher-level concepts, including hallmarks of unsafe practices, factors that contribute to unsafe practice, preceptors' perceptions and feelings, grading issues, and strategies for managing unsafe practice.

Selective Coding

Selective coding, the next level of analysis, is an integral phase in the discovery of the core category. During selective coding I moved from data analysis to concept and theory development through the process of data reduction by filtering information relevant to the topic, discarding extraneous information, and sampling selectively. During this stage I identified the core category that ties all other categories in the theory together and related it to other categories (Glaser, 1978). This category may be a process, a condition, or a consequence, and a storyline is often used to describe relationships between the core category and other concepts. Selective coding is often referred to as a process of *reduction* because it is designed specifically to facilitate the search for the core variable (Stern, 1980). Through this process I attempted to delimit the coding to only

those categories related to the core variable(s), which in turn acted as a guide for further data collection and analysis (Glaser, 1978; Myrick, 1998). By doing so, I hoped to focus the research on one of the several basic social processes or conditions present in the data. During this analytic phase the following questions guided me (Glaser & Strauss, 1967) in describing the basic social psychological processes: What is going on in the data? What is the focus of the study and the relationship of the data to the study? With what problem are the preceptors dealing as they work with students with unsafe practices? What processes are helping the participants to cope with the challenges of precepting such students? (Myrick, 1998; Streubert & Carpenter, 1999). As well, the role of the extant literature became more important at this stage, and I turned to it to acquire sensitivity to and knowledge on grounded concepts. Thus, I read the literature as a source of further data and compared it with the existing grounded data. Through the process of reduction and comparison, the core variable for the study emerged, and I labelled it "Promoting student learning *while* preserving patient safety." Once I had identified the core category, I concentrated on modifying the categories and integrating the theory with the categories and subcategories (McCann & Clark, 2003c).

Memoing

Another important step in the analytic process is writing memos, which are notes that the researcher documents throughout the research process to record and explain the theory as it is being developed (McCann & Clark, 2003a). As Glaser (1978) explained, memos are "the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding" (p. 83). In grounded theory, memos are used for three purposes: (a) to make explicit the researcher's preexisting assumptions, (b) to record

methodological decisions regarding the conduct of the study, and (c) to speculate on and analyze the data (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Memoing raises data to a conceptual level, helps to develop the properties of each category, and presents hypotheses about connections between categories. As Myrick (1998) explained, "Hypotheses about linkages between categories and/or their properties are delineated with these linkages, which are then integrated with clusters of other categories that in turn help to generate the theory" (pp. 42-43). It is also through memos that the emerging theory begins to locate (Glaser, 1978). During memo writing I was guided by a number of questions that, while allowing for true emergence of the categories and their properties, helped to keep me from becoming lost in reexperiencing the data (Glaser, 1978; Myrick, 1998). These questions included the following: What relationship does one code have with another? Are they separate codes, or is one code a property or a phase in another? Was one event the cause or the consequence of another, and what were the conditions that influenced the codes? For example, what was the relationship between the unprofessional behaviour and the difficult or stressful experience? What was the relationship between a lack of knowledge and poor skill performance? Was the lack of knowledge and skills the cause of nervousness?

Memoing is an essential tool for recording or capturing ideas and for abstraction and theory development, which continue throughout the research process (Hutchinson, 1993). Glaser (1978) cautioned, "If the analyst skips this stage by going directly from coding to sorting or writing, he is not doing grounded theory" (p. 83). Memoing is inductive during the process of conceptualizing the data or coding and deductive during

the process of assessing how the conceptual labels, categories, and subcategories fit together (Hutchinson, 1993).

Rigour (Trustworthiness)

According to Guba and Lincoln (1994), there are four criteria for the assessment of rigour or trustworthiness in qualitative research: (a) credibility for the assessment of truth-value; (b) fittingness (transferability) for the assessment of applicability, (c) auditability for the assessment of consistency, and (d) confirmability for the assessment of neutrality.

Credibility

In a qualitative research study, *credibility* is demonstrated when the participants immediately recognize the reported research findings as their own experiences (Streubert & Carpenter, 1999). I ensured that the participants validated the findings of the study through member checks and member validation as Sandelowski (1986) advised. Once I had transcribed the audiotaped interviews, I gave the participants a chance to review them. I also achieved credibility by engaging with the participants over time and developing rapport, establishing trust, and working collaboratively with them.

The credibility of the qualitative study is also dependent on the credibility of the researcher (Patton, 1990) because in qualitative research the researcher is seen as the instrument though which the data collection and analysis are conducted. Therefore, to enhance credibility, researchers should make explicit what they bring in terms of qualifications, experience, and perspective (Patton 1990).

Professional and personal experiences and earlier studies had an impact on the selection of my research topic. I have worked as a nurse educator in the Registered

Nursing Program for 12 years and have been a registered nurse/midwife for 22 years. Working within nursing education over this time has meant that I have, in my role as an educator, had experiences of either working with student engaging in unsafe practice or supporting preceptors and colleagues who have faced the dilemma of whether to pass or fail such student in the clinical area.

My research plan for my PhD program was to conduct research in clinical teaching and evaluation, and my specific projects were to be related to (a) innovative teaching strategies that would enhance teaching and learning and (b) evaluation of students' learning outcomes. Preceptorship, on the other hand, has been my area of interest for some time. The significance of exploring this particular area came about in the fall of 2003 when I conducted a literature review for one of my independent-study courses in which I examined the practical issues related to clinical evaluation in preceptorship. One recurrent issue in the literature was that few preceptors are guided in the teaching and clinical evaluation of nursing students, as well as the fact that no study has been done to explore the challenges of precepting an unsafe student. It is from this background that I chose the current research topic as the subject for my PhD thesis.

Fittingness (Transferability)

Fittingness refers to the probability that the research findings can have meaning or can be applied to contexts other than the one studied (Streubert & Carpenter, 1999). Fittingness was enhanced by collecting the data from different acute care settings. I ensured that preceptors outside the study setting (independent experts) or other provinces within Canada read and commented on the credibility and transferability of the findings (Benton, 1996; Duffy, 2004).

Auditability (Dependability)

Auditability refers to the ability of another researcher to follow the thinking, methods, and conclusion of the original researcher (Streubert & Carpenter, 1999). Beck (1993) asserted that auditability is demonstrated when another researcher is able to follow the audit or decision trail of all of the decisions that the researcher makes at every stage of the data analysis. Therefore I ensured there is a comprehensive audit trail for future use by others. I also achieved dependability by asking my thesis supervisor to independently categorize the items as a check against bias.

Confirmability

If a study demonstrates credibility, auditability, and transferability or fittingness, it is also said to exhibit *confirmability* (Streubert & Carpenter, 1999). I achieved confirmability by keeping coded written material, memos, and field notes, as well as an audit trail.

Therefore, throughout the study I took measures to ensure that I achieved and maintained these criteria to enhance the rigour of the study.

Limitations

The major limitations of the study include the following:

1. Because I confined the study to preceptors in one particular course at one particular university, the results cannot be generalized to all undergraduate preceptors.
2. Only those preceptors who had past experiences in precepting a student whose level of practice was unsafe and a few preceptors with no direct experience with such students participated in the study (retrospectively), which thus

excluded those who were currently precepting an unsafe student at the time of data collection. I excluded these latter groups because of the sensitive nature of the topic and the possibility of identifying the student.

3. The data that I collected through interviews may have increased bias because the participants may have revealed what they wanted or would have wanted to do, but not what they actually did.

CHAPTER 4:

FINDINGS

The Process of Precepting Students with Unsafe Practice

The findings from the data analysis are presented in this chapter. *"Promoting student learning while preserving patient safety"* emerged as the core variable. Five major categories, with subcategories, emerged from the data (Figure 1): (a) hallmarks of unsafe practice, (b) factors that contribute to unsafe practice, (c) preceptors' perceptions and feelings, (d) issues related to grading, and (e) strategies for managing students with unsafe practices.

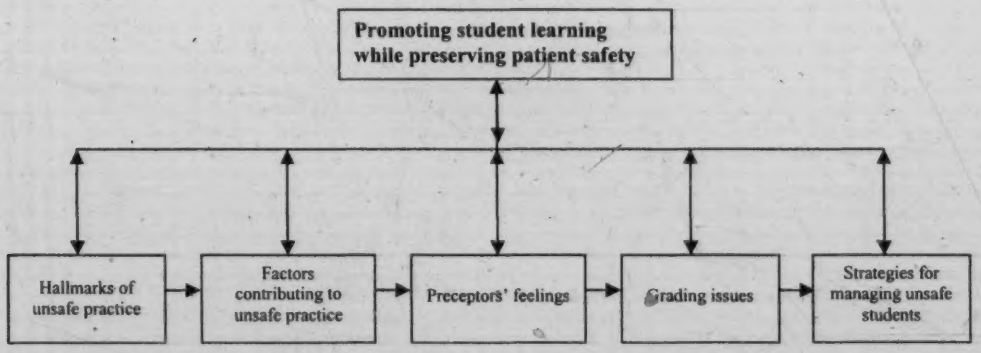
Promoting student learning while preserving patient safety
Hallmarks of unsafe practice
Factors contributing to unsafe practice
Preceptors' feelings
Grading issues
Strategies for managing unsafe students

Figure 1. The core variable and the five categories.

Figure 1 represents the relationship of the core variable to the five main categories and the relationships among the major categories. The core variable of promoting student learning while preserving patient safety reflects the main concern for preceptors as they face the dilemma of trying to facilitate students' learning experiences while ensuring safe and competent care for their patients.

The five major categories, with their subcategories, represent the processes that preceptors use to manage students who engage in unsafe practice. The study findings reveal that early identification of and intervention with students with unsafe practice is important during the preceptorship experience. The first step in managing unsafe practice is to recognize or identify hallmarks of unsafe clinical performance. Once they recognized unsafe practice, the preceptors' next step was to discover why the student was engaging in unsafe practice to be able to specify the problem. To do this, preceptors had to determine the underlying causes or factors that contributed to the problem. They saw this step as crucial in managing unsafe practice because the plan of action or kind of strategies used depend on an accurate diagnosis of the problem. For example, accurate assessment of the student's problem and level of competence is important in planning learning experiences and critical to assuring patient safety or promoting student learning while preserving patient safety.

The core variable of promoting student learning while preserving patient safety learning was also reflected in the preceptor's perceptions and feelings. They reported feeling insecure as they try to balance the need to give students the opportunity to practice in the practice setting with the need to maintain patient safety.

The preceptors identified the competing or conflicting responsibilities that they face: providing learning opportunities to students, maintaining the values and standards of the profession, and fulfilling their role as gatekeepers of the profession by ensuring that only those who meet the course objectives graduate from the program. The preceptors reported a variety of affective responses, including guilt, anxiety, and self-doubt, as they move through the process of evaluating borderline or unsafe students.

The preceptors' responses (perceptions and feelings) to students' unsafe clinical performance may depend in part on the type and extent of the identified problem. For example, the preceptors in this study considered students with attitudinal problems as the most difficult and most frustrating to manage. The range of feelings that they experience can also interfere with and influence the decision-making process related to supervision, evaluation, and grading and the kind of remedial intervention that the student might need. For example, fears associated with failure can result in the preceptor's giving the benefit of the doubt to a borderline student or an extraordinary amount of support to ensure a pass grade (Ilott & Murphy, 1997). The preceptors in this study revealed a variety of affective feelings that have influenced them in deciding not to fail borderline students.

Last, as stated above, the core variable of promoting students' learning while preserving patient safety was reflected in the strategies that the preceptors recommended for dealing with students with unsafe student. For instance, the preceptors explained that once they detect unsafe practice, they supervise the students more closely as they develop clinical competence and gradually allow them clinical independence to ensure that patient safety is not compromised.

Overview of the Main Categories

Unsafe practice includes behaviour that reflects lack of knowledge, skill, or clinical judgment or any unprofessional or unethical conduct by a student that could jeopardize the client's life, health, or safety. To pass the fourth-year final practicum course, students must demonstrate safe, ethical nursing practice and professional behaviour. It is important for preceptors to be able to recognize and manage students' unsafe practice early for the sake of patient safety. The first process in dealing with

students with unsafe practice is identifying these unsafe practices, and preceptors must be able to recognize the signs or hallmarks of poor or unsafe performance. Thus, the preceptors were asked, "What students' actions, behaviour, and attitudes would you identify as unsafe?"

Category 1: Hallmarks of Unsafe Practice

To identify unsafe practice, preceptors have to recognize the red flags or hallmarks of unsafe clinical performance; this category emerged from the data analysis. All of the preceptors in this study reported that hallmarks of unsafe practice occurred early in the preceptorship experience, as illustrated in the following comments:

> Actually, some of them you get either on the first day—you just think, My goodness, they are soon to the end of their practicum [program], and I feel like I got a student fresh from high school. So you can pick a little bit the first day already. And I had one particular student, I picked a twelfth error within the morning. Already it was to the point where it was almost, you were fearsome. . . . It was very difficult. I think fairly early on I knew there was an indication that the student might be unsafe. She seemed distracted. . . . Things that we'd go over, I'd have to repeat myself the next day.

The preceptors described several behaviours or actions that prompted them to consider the possibility of unsafe practice. These included three subcategories: (a) inability to demonstrate knowledge and skills, (b) poor communication skills, (c) attitude problems, and (d) unprofessional behaviour.

Inability to Demonstrate Basic Knowledge and Skills

Under this subcategory, the preceptors identified five additional subcategories: (a) the students' lack of knowledge and poor skill performance, which was the most common behaviour that half of the preceptors identified as prompting them to intervene; (b) sloppiness or lack of organizational skills, which nearly half of the preceptors cited; (c) students' inability to ask questions, cited by one third of the participants; (d) students'

inability to follow instruction, which results in frequent repetitive mistakes, mentioned by one quarter of the preceptors; and (e) students' not practicing basic safety measures (such as aseptic technique), which a few preceptors identified.

Inadequate knowledge and inability to perform skills. In the preceptorship experience the students are expected to practice with increasing independence under the supervision of their preceptors (Faculty of Nursing, 2004b). However, this was not the case with some of the students, as reflected in the following comment:

> Her skills were poor, and she just wasn't able to cope with the workload and that sort of stuff. . . . She could barely handle one patient at all, so she needed a lot of help, and, you think at this point they should be able at least to have four patients. . . . You still kind of give them two at first and see how they do, but, they are ready to graduate.

The main concern of the preceptors was that students are not well prepared for their preceptorship experience. The majority of preceptors commented that by the time most of the students started their preceptorship, they still lacked basic clinical skills. As one preceptor explained, "Technique, nervousness; and, she was just poor all round. She couldn't. . . connect theory with practice, and she was not able to critically analyze or anything like that, so, yes, she couldn't think for herself." Most of these preceptors believed that students do not learn enough practical skills in the university program and that if they were better prepared, the preceptors would not have to spend so much time teaching the basic skills because the instructors would already have taught them earlier in the program. They believed that their role at this stage was simply to polish students' previously acquired skills and not to teach the basics. One preceptor commented:

> I don't really mind doing it, but I would appreciate when we get a student that's not up to par—because by the time they are ready to graduate, there shouldn't be a lot of stuff that I have . . . to teach them. I should serve as just kind of smooth

> the edges, so to speak. . . . But it's really hard when they come; they haven't done this, they haven't done that. . . . I shouldn't really be teaching that. I think that should have been done with the instructor.

The preceptors appreciated and acknowledged that students will not have learned some skills at university. However, they feel frustrated when some students present with minimal clinical skills, which means that the preceptors have to spend time teaching the basic skills instead of just providing the finishing touches prior to graduation.

Other preceptors believed that unsafe students lack the knowledge base to carry out the required skills. Under this subcategory, for instance, one of the most striking findings was that medication errors are very common among students, which three quarters of the preceptors who were interviewed reported. To ensure safe medication administration, students need to have adequate knowledge of the drugs and the skills required to administer them. Indeed, if students do not have the necessary knowledge and skills, they are at greater risk for medication errors. One preceptor described a student's error:

> There was a medication incident. Specifically, I believe it was Zofran, and I think the order was 4 mg, and she was going to give two [tablets]. It comes in a 4-mg dose, and she was going to give two [tablets], so the patient would have had 8 [mgs]. . . . There were other cases where she wasn't reading something or didn't compute properly, or she just didn't understand its perspective. . . . But quite often she got things wrong. . . . You have to know the medications; you have to do that, and she just wasn't.

One of the critical skills for nursing students is the ability to calculate drug doses accurately. However, the majority of the preceptors in this study maintained that some students are deficient in this skill. As one preceptor explained:

> Just simple things like medications. In 100 ccs you are supposed to give over two hours, so what are you going to run it at? She would say "25," and so, [I explain] Okay, now think about this the other way. If you run 25 in two hours, how much

> of the 100 will go in?" [She would say] "All; the whole thing," and [I say] "Okay, in Grade One or Grade Two you learned how to divide. . . . I give you two 25 cents, and you tell me that makes a dollar." It was scary.

The preceptor described this as a "very painful experience," considering that this was simple arithmetic that the student could not figure out.

Sloppiness or lack of organizational skills. The second most common behaviour in this category that prompted the preceptors to identify unsafe practice was related to students' inability to organize basic patient care activities or their demonstration of careless behaviour. Although preceptors expect students in their final practicum to be well organized and to have stronger time-management skills than they did earlier in their training, this is not always the case. Some of the preceptors described instances in which their students had difficulties with organizing and completing their work in a timely manner. One preceptor described a student who displayed careless behaviour on the unit:

> There was. . . an incident where one of my students accidentally knocked over some pills. I think they were in a bubble pack or something. The patient brought them in. She had them all folded up, and somehow they got knocked over, and she scrambled to recollect them all. And she didn't know if she got them all or she didn't get them all. . . . She would leave stuff lying around, leaving the med room open,. . . not signing up for medications. I had to constantly be on her back all the time.

Apart from displaying careless behaviour, the student did not report the incident to the preceptor immediately. Instead, the preceptor was told about it two days later. Students who do not report such important incidents to their preceptors are a cause for concern. Although the preceptor explained that these behaviours did not pose an immediate danger to the patients, there is a chance that the student will repeat the behaviour later in his or her practice, which could have more serious effects. By not disclosing the incident to the

preceptor, the student was being dishonest, which was perhaps of greater concern to the preceptor.

Not asking questions. The preceptors also prefer students who ask questions to those who do not and then make mistakes. They reported that they tend to trust students who asked questions because they can then ascertain the students' level of competence and assist them accordingly. Moreover, the preceptors indicated that they become more concerned with students who do not know when to seek appropriate assistance with patient care activities. One preceptor cited an incident with a student:

> Also not telling a nurse if something were to happen. . . She just brought the patient back from the shower. The person was really short of breath, but she wanted to get him, [and] she said, "Oh, can you help me get him into bed?" I go in, I'm saying, "Let's check his oxygen levels"; they were dropping, and she was saying, "Oh, it's coming up." And I looked, and it was actually going down, and then [she said] "Oh, it is going down." She didn't know what to do, but she was not asking so much for help.

This incident illustrates that when a student does not know when to ask for assistance, it increases the risk of error and causes the level of trust between the preceptor and student to decrease.

Inability to follow instructions. Other behaviour that was of great concern and frustration to the preceptors was related to the students' inability to follow instructions: "One day you could tell her something three times, and then she will still do it wrong"; and

> You tell her to go into a patient's room to discontinue this IV; then they always go to the wrong patient. . . . Every time you give them instruction, it seems like they will do it wrong. Those, I think, were the hardest.

Although the preceptors acknowledged that "we all make mistakes," they still believed that when a student does not follow instructions and makes repetitive errors, he or she is unsafe and therefore should not be trusted with patient safety.

Students' not practicing basic safety measures. Another subcategory of behaviour that a few preceptors identified was related to students who do not practice basic safety measures or principles of surgical asepsis.

Attitude Problems

Under this subcategory, the most common behaviour that alerted preceptors to unsafe practice was related to overconfidence or a 'know-it-all' attitude, such as performing procedures without adequate prerequisite experience or displaying an unenthusiastic attitude toward learning and work. Other common behaviours included defensiveness or an unreceptive attitude to feedback and an indifferent, 'I don't care' kind of attitude.

Overconfidence. The majority of the preceptors who were interviewed indicated that students with attitude problems are the most difficult to deal with. For instance, three quarters of the preceptors viewed most of the fourth-year students as overconfident or "cocky." They believed that overconfidence can be unsafe because, in most cases, students think that they know what they are doing when they actually do not, in which case they are being untruthful. In fact, one preceptor was concerned that because of overconfidence, some students might perform tasks that only an RN should be doing, such as drawing blood from a blood line. For example, one preceptor described her experience with a student who thought that she knew how to perform a procedure when, in fact, she did not:

> When we have to put the re-breather back on him, she's like, "[Yes, yes]." I [said] "Okay, well, that's great." I ended up doing it. In terms of that, students who think they know everything, I find [this] very scary.

The preceptors explained that some students feel so overconfident that when they supervise them closely to ensure that they do not make errors, the students feel that the preceptor does not trust them, even though the preceptor's intention is simply to establish the students' level of competence before allowing them clinical independence. This can be frustrating for both parties.

No motivation to learn or work. Nearly half of the preceptors acknowledged that it is difficult and frustrating to work with students who do not seem to be interested in learning because they feel that they have accomplished all the tasks, are not interested in nursing, or are lazy. This view is confirmed in the following quotations: "She didn't seem to be interested in learning either, because I would go with her to do things, but she just wasn't around. She just disappeared"; and

> I would have to push her. . . . She would try to do as little as she could because as a preceptor I would still be there to help her out with certain things. . . . I still found she preferred to do the minimum, but I still had to really push her.

Moreover, the preceptors expressed concern about students who tend to dismiss certain learning opportunities once they have accomplished a task by saying "Done that before" or "I don't want to repeat it":

> Some of them, when you say, "well, would you like to do a catheterization?" she says, "Oh, I have already done that." And I am thinking, Wow! Practice makes perfect...Why not go for another one? But with that kind of attitude then, it is really hard to kind of teach them anything.

Defensiveness or unreceptive attitude towards feedback. Another common attitude problem that a third of the preceptors considered unsafe and very challenging is

defensiveness or an unreceptive attitude towards feedback. The preceptors believed that students who are unreceptive towards feedback are the most difficult to teach and manage and that it is difficult to trust a student who does not want to be corrected. One preceptor described a student who was very unreceptive towards feedback. Whenever the student was challenged, she defended herself with a range of excuses rather than admitting her mistake and learning from it. This preceptor explained:

> When I caught her doing unsafe behaviour, it was always somebody else's fault; it wasn't hers. . . . I found her very cavalier about the errors. . . . When I approached her and said, "No, this is a problem because this is unsafe," she became very defensive and walked away. . . . So I found it very difficult to try and correct some of her errors.

The preceptors were also concerned about students who do not seem alert to the possibility of making mistakes:

> It was the medication we had mixed, and we are to mix it four times that day, and the first three times we did it together. The fourth time she got it ready and I checked it, but she mixed it wrong. . . . And when I found her I said, "Okay, why don't you come in? There is something wrong with the way this medicine was mixed. I want you to tell me what it was." And she said, "I can figure it out." But I told her what it was, and she [said], "Oh, why should that make a difference?"

This particular example illustrates how frustrating it can be for preceptors to work with students who are unsafe and unreceptive towards feedback. However, some preceptors still believed that it is important for them to continue working with such students to ensure that they become safe and competent practitioners. As one preceptor asserted:

> I feel that it is our responsibility legally and morally to. . . deal with it, because when they graduate there's not going to be somebody looking over their shoulder every minute, and if they are not willing to take responsibility now, how will they take responsibility when they are even being monitored even less frequently?

Unprofessional Behaviour

The preceptors also described a number of behaviours and actions that they identified as unprofessional behaviour that related mainly to poor work ethic, lack of confidence or extreme nervousness, dishonesty, and intentional unsafe behaviour.

Poor work ethic. More than half of the preceptors identified behaviours related to a poor work ethic, most of which demonstrate an inability to meet the demands and expectations of a work environment, such as negligence, laziness, gossiping, crying, or eating on the unit. One preceptor described a student who she felt was lazy and disrespectful to the staff on the unit:

> She spent a lot of time visiting and laughing and just having a good time. . . . She comes in to the report, puts her feet on the table, and she eats her breakfast in the report. She didn't seem to have respect. I don't know if it was lack of respect or if it's just the generation thing where people are more relaxed and think that's okay.

Other preceptors described students who would arrive on duty with unresolved personal problems and cry on the unit; for example:

> Basically, she always had a headache, she always felt nauseated, she was always crying, and she would just talk about the family problems. So when it came to working, her mind was not on the job; it was on whatever was going on in her life. So, [yes], it was very difficult to teach somebody like that.

Lack of confidence. About half of the preceptors identified extreme nervousness as a warning sign of poor performance or unsafe practice. A student who lacks confidence in performing a skill may demonstrate extreme nervousness. One preceptor remarked, "She was extremely nervous. Even the patient commented that she was nervous." Other preceptors also commented that when students are hesitant and unsure, it is difficult to trust them with patient safety.

Dishonesty. One third of the preceptors identified dishonest behaviour as unprofessional. This includes lying, hiding errors, and not admitting their mistakes, as evidenced in the following comments:

> We were working on a Sunday, and the order got written by a nurse. She [the nurse] wrote it wrong, but she verbally said it right, and he [the student] checked it with the other nurses of the group, so he knows that it was right. But when he put it down on paper, because the order had been written for a certain amount, that's the amount he put down instead of the amount he actually gave.

Another preceptor confirmed this concern:

> She hid her errors, and that was a cause for concern. It wasn't so much the errors that she was doing; it was the fact that she would hide them or say it was somebody else or "I didn't do that." So that was my concern as a nurse.

Most preceptors found it difficult to trust students who lie when patient safety is involved and were concerned about students who display dishonesty in their practice.

Intentional unsafe practice. Other behaviour that alerts preceptors to unsafe practice is related to verbal or physical abuse of patients and acts of embellishment. However, there was no direct evidence of students' either verbally or physically abusing clients. One preceptor described a student who would embellish stories, which led the preceptor to distrust this person:

> She also embellished things, sort of make stories up. . . . And the stories came, like insignificant little things like talking about the price of a car. . . . So these were little things, but I could see that there was a problem with embellishment, and I took her to task, saying..."I have to be able to trust you, and I don't want you to embellish stories. If I am asking you about a patient, I want that the information you are giving me is true and accurate and it's not being painted in any way."

Poor Communication Skills

Behaviour related to poor communication or interpersonal skills concerns mainly inappropriate interaction with the preceptor or instructor (being too argumentative and disrespectful), inappropriate interaction with patients, and inappropriate nonverbal communication, such as rolling the eyes, sighing in the presence of patients, chewing gum, or yawning.

Inappropriate interaction with preceptors or instructors. This subcategory was the second most cited unprofessional behaviour and was identified by about half of the preceptors. It includes personal behaviour that interferes with students' ability to self-evaluate and perform their work responsibilities. For example, one preceptor recalled an incident in which a student had an intense argument with her instructor, to the point that the preceptor believed that the student was being disrespectful:

> The student was very argumentative. . . . I talked to her, but she was arguing in the meeting with the teacher, and then she burst into tears. . . . She was very upset. . . . I had to kind of defuse that situation because we needed to go back to the patient; we had medications to give.

Another preceptor described an encounter with a student after giving the student her final evaluation:

> It seemed to me that she was aware that she was having problems, but when the final evaluation came, she was extremely unsatisfied with it. She cried and cried, . . . basically told me it was my fault that she was going to fail. It wasn't her fault; it was my fault because I was a poor preceptor. And she had said that previously of all of her other preceptorships, and in all the other courses she was an honours student.

Inappropriate interaction with patients. One quarter of the preceptors, most of whom were working in psychiatric settings, identified inappropriate interaction with patients as including boundary crossing and self-disclosure. For instance, one preceptor

recalled an incident that she described as unprofessional and "kind of weird" in which she saw a student on her knees beside the bed talking to a patient. Other preceptors gave examples of students' sharing personal information that had nothing to do with the patient's therapy.

Inappropriate nonverbal interaction with preceptors. The other behaviour that the preceptors identified as unprofessional was related to inappropriate nonverbal interaction with preceptors, such as rolling the eyes, yawning, or sighing in the presence of patients. One of the preceptors commented:

> I will be in the room and trying to teach her to do a dressing, and she will be rolling her eyes and sighing in front of the patient, which I thought is unprofessional. . . . Sometimes you have to be instructing them, and she just really would get her back up a lot of the time. . . . That was very difficult; it really made a long four months.

Category 2: Factors That Contribute to Unsafe Practice

During the interview, the preceptors were asked what they thought were the contributing factors to unsafe practice. About one third believed that students are unsafe because they do not have enough time to practice clinical skills and that more emphasis in the university nursing program is placed on theoretical assignments rather than on clinical practice. As a result, instead of practicing clinical skills, students spend time reading for their theoretical exams or writing assignments during their practical experience. One remarked:

> I have had students having assignments, papers due while doing full-time work with me. All they are concerned with is to get their papers done. . . . They spend so much time worried about having this paper done and not concentrating on their actual work experience. . . . [One student was] concerned about the test, and all she wanted to do was to study and as such could not concentrate on [her clinical practice].

Other preceptors thought that previous educational preparation also contributes to unsafe practices. For example, one preceptor described a student who did not want to change a drawing needle because her previous instructors had told her that this practice was a waste of money and that it did not matter if glass fragments were drawn into the needle.

Some preceptors believed that the kind of environment in which students are placed influences unsafe practice. For instance, on units with too few learning opportunities, they may not acquire adequate experience. Other preceptors reported that students may feel scared in a busy or completely new setting. One preceptor also described a student who she believed was intimidated by the type of client that she had been assigned, which ultimately affected her learning experience on that particular unit. Some preceptors identified a language barrier as contributing to unsafe practices because students may misinterpret what others are saying. As one preceptor suggested, "I think it was a language problem as well. . . Then she would take a [psychiatric] patient out of the unit without consulting with the rest of [the staff], and that was a pretty dangerous thing."

Some preceptors saw personal and professional stress related mainly to lifestyle as a factor that contributes to unsafe practice. For example, some acknowledged that some students work while studying either to pay for their education or to maintain their families. This means that at times they do not have enough time to rest or sleep and are therefore likely to lose concentration and make errors during clinical practice, as evidenced in the following comment:

> There was one day she was extremely tired, and she was kind of making small mistakes, and I had to tell her things over and over again. I talked to her, and when I had questioned her, [I found] she had financial restraints. She was also

> working at another job, and then by the time I got her, that was her ninth shift in a row.

Another preceptor described a student who was so stressed because of family problems that it interfered with her learning during the practicum. Other preceptors cited student health problems as another contributing factor to unsafe practice: "This girl had so many health problems she was physically unable to do nursing because she didn't really seem to care as to whether she learned. She didn't seem to be very motivated." Another preceptor described a student who she and the instructor suspected had some sort of learning disability, which she thought contributed to the student's extreme nervousness when she performed clinical skills.

Category 3: Preceptors' Perceptions and Feelings

Preceptors' Positive Perceptions

About one third of the participants in this study enjoyed precepting students and described watching students as they progress as an intrinsically rewarding experience. As one commented:

> For the most part I really enjoyed it. It's really kind of neat to see them come onto the unit, and they've never had more than two or three patients. [But by the] time they leave, they are very confident, competent, and they can handle six patients; . . . they can handle a severe crash. And it's so nice to see them take that next step, and you know that when they get a job they are going to be just fine. So it's really a nice feeling that you can do that.

The preceptors also acknowledged that in the process they learn a great deal from their students: "As I said, I learn stuff, because they ask questions which I sometimes don't even know the answers to any more. . . . Therefore I have to go out and do the research, and then we learn together"; and

> I have learnt from every one of my students. . . . they are all different individuals; they all bring things. And as I said, even talking with them about their extracurricular activities, they do help build the person. And, no, I enjoy them; they are good to have around.

One preceptor suggested that precepting students has improved her own critical-thinking skills and encouraged her to engage in self-reflection:

> I think it's good for the preceptor as a learning experience as well, because it makes her think about what she is doing and why she is doing it in order to explain that to the student. I think sometimes you can kind of turn to autopilot when you have been doing the same thing for a while. . . . It makes you do a self-evaluation.

The preceptors acknowledged the importance of the preceptorship experience for students and believed that it offers students the opportunity to integrate theory into practice and to gain a sense of nursing in the real world.

Preceptors' Negative Perceptions

Although the preceptors described precepting students as an interesting and rewarding experience, they also acknowledged that it can be demanding and challenging in terms of the extra time that they spend in preparation. As one preceptor explained:

> It is actually a lot of work. . . . I actually would rather have not been a preceptor. I read a lot, and asking the questions and trying to make sure, . . . I find [it is] a substantial amount of work.

Because of this demand on their time, some preceptors may experience 'burnout' and choose not to precept students in the future. As pointed out earlier, the preceptors also reported feelings of frustration in dealing with students who are unenthusiastic about learning or practicing skills. The majority of the preceptors also indicated that precepting a student with unsafe practices can be difficult, frustrating, and time consuming because they have to spend a great deal of time teaching and guiding them, which they feel

doubles their regular workload: "It's quite difficult if you get the odd student that isn't good because you spend so much extra time to teach them."

The preceptors described precepting a student with unsafe practice as stressful and anxiety provoking because such students need to be closely monitored. They felt responsible for facilitating students' learning experience and providing safe and competent care for their patients. The preceptors expressed a sense of fear about working with students who exhibit unsafe practices and feelings of insecurity; although they want to give students the opportunity to practice in the clinical setting or allow them clinical independence, the patient's safety is foremost in their minds. As one preceptor explained:

> It's frustrating in some way because you are not quite sure how you are supposed to stop it. . . . You don't want to jump right in because you don't want to make the patient uncomfortable, or you don't want to make the student uncomfortable.

These preceptors found it difficult to balance the need to supervise students closely with the need to allow them clinical independence.

The process of evaluating a student with unsafe practices is another source of stress for the preceptors in this study. Most found it difficult and time consuming because of the paperwork involved. They added that the evaluation process can be frustrating especially when dealing with students who are overconfident and not receptive to feedback.

Preceptors' Feelings After Failing a Student

The preceptors reported a variety of feelings, including relief, fear, anxiety, self-doubt, anger, and frustration, as they went through the evaluation process of a student with unsafe clinical practices. Five preceptors reported that they have had the experience of failing a student. However, although some reported feelings of guilt or self-doubt,

others actually felt good about the decision. One preceptor who had recently failed a student indicated that it was difficult and very uncomfortable for her to make a final decision because she had not had enough time to work with the student:

> One of the other girls on the unit had her for probably 90% of it, and this girl went on vacation and was already having problems with her and kind of gave me a heads up. . . . So I had her for the last two or three weeks of the preceptorship, and I was the one doing her final evaluation. And I was quite uncomfortable saying she was safe to give her a pass on her final evaluation. It was very uncomfortable.

This preceptor explained that the instructor with whom she was working was supportive and in constant contact. When pressed further about how she felt after recommending that the student repeat her practicum, the preceptor stated that she was comfortable because she had the instructor's support. The instructor had reminded her of the old test:

> Was I comfortable if she were to take care of my mother? Those kinds of questions. Do you feel safe with this girl who is going to be on your floor working? If she was looking after you or after your mother, would you feel comfortable with her? She said to answer her honestly.

Another preceptor described her experience after failing a student as extremely stressful and decided not to take any more students thereafter. Though she had never failed a student before, the instructor was very supportive, which was helpful. From the above comments it can be seen that it is easier for preceptors to make such critical decisions when they have the support and guidance of the instructor. However, although most of the preceptors commented positively about their experiences with instructors, one felt otherwise and described her experience as frustrating. After realizing that her student was unsafe, she communicated this observation to the instructor, who did not respond in a supportive or receptive manner. She explained:

> She wasn't receptive to hearing my concerns about this student. I would have preferred at that time as well to take the instructor aside from the student and

> express my concerns and see if we could come up with an action plan. She did not really even want to listen, and she left the unit quickly. . . . I thought, I had called looking for advice, not looking to blame the student or myself. And so I found it angering, and I was bitter and resentful that the instructor would not help.

The findings reveal the important role of instructors especially when preceptors are dealing with students who are struggling during their practicum. It is therefore essential that instructors make themselves available and support preceptors, especially when challenging situations arise. One preceptor suggested:

> I think they should be more involved with the student for sure, because on average you will see the instructor probably twice in the whole placement, and they would only be on the unit for about two or three minutes unless there was a problem, and in which case you get them in setting up the meetings kind of stuff.

Preceptors need support and advice from instructors to enable them to make critical decisions about a student's clinical competence with the ultimate goal of registration in mind.

Category 4: Grading Issues

One of the guiding questions of the interview was, "In your experience, do students sometimes pass clinical placements without having gained sufficient competence?" One major category, grading issues, and the subcategory reasons for failure to fail students emerged from the preceptors' responses to this question. The majority of the preceptors who were interviewed acknowledged that, indeed, sometimes students pass their clinical practicum without having gained sufficient clinical experience:

> I've encountered a number of grad nurses on our unit that have come. . . . In my very quick experience with them, . . . you can tell that they lack a number of skills. They lack foresight to understand; . . . the lack of their knowledge leads to problems with their patients. . . . But their skills are just not at par.

Giving an injection, for instance, is considered one of the basic clinical skills that students are expected to have mastered in their previous practical courses. However, one preceptor gave an example of a BScN graduate who had completed her training without having given an injection, and two others described incidents in which students in their final practicum did not know how to give an injection. One explained:

> I said, "Have you been through surgery and medicine already? How did you not know how to give an injection? . . . And you are now in psychiatric, [and] it's your final practicum." To me, they are not getting enough hands on, enough experience for actual nursing care.

These participants confirmed that some students are not acquiring sufficient practical skills in the university program. One preceptor commented on the context-based learning (CBL) approach that is currently used in the university program: "[Students] don't get a lot of practical skills, . . . especially with the context-based nursing. But I do find they are very eager to learn; . . . it's just that they don't really get skills or a very good basic knowledge." This preceptor expressed her opinion that "the university teaches students how to think, but not what to think." Some preceptors explained that most third-year students give more credence to what they learned during the summer months while working as employed nursing students (UNEs) than to what they learned during all of their previous clinical courses at the university. These preceptors affirmed that students learn more practical skills during this work experience. One preceptor suggested that the university program is educating students to become good researchers, but not good bedside nurses. One preceptor commented specifically on after-degree students:

> I believe I and a lot of other nurses on this floor and this hospital do not agree with the [after-degree program]. . . . That program does not provide them with enough background; . . . they don't have enough experience on the floor. They

> don't have any organization; they don't seem to have the knowledge. They just seem very lost, and I just feel bad for them. . . . I think they are struggling with it.

Although the preceptors appreciated the theoretical and broad, research-based knowledge that the university offers students, they also believed that because nursing is a practical discipline, students need to be given sufficient time for clinical experience to acquire the skills required of a competent graduate nurse.

The other striking concern of the preceptors was that sometimes instructors pass students even when the preceptors have raised concerns about their poor clinical performance:

> I have heard that when a preceptor is not happy with a student, . . . for some reason she still passes. And I know of an incident, we were all wondering, "Oh, she is still working here." It seems the instructor just passed her anyway, and no explanation was given as to why she was passed.

Another related issue that two preceptors raised was that sometimes instructors assign students' final grades before they have seen the preceptors' evaluative comments. This may have implications for whether students take their preceptorship experience seriously.

Reasons for Failure to Fail Borderline or Unsafe Students

During the interview the preceptors were asked why it is so difficult to fail students in the clinical practice component. The majority acknowledged that assigning a failing grade is one of the most challenging responsibilities:

> It's a really hard decision to make. Sometimes as a preceptor it's one you don't want to make. You don't want them to be disappointed in you. You don't want them to have to repeat it, and that's probably one of the hardest things to do as a preceptor, to say "You are not doing good enough."

The participants cited several reasons that students are passed when their performance is not up to standard. Some acknowledged that they have been reluctant to fail a student because of their lack of experience or confidence in their preceptor role. One commented, "I guess it is my lack of experience of being a preceptor. I didn't really know how to do it in a nice way probably, so I let it go."

Other preceptors acknowledged passing students because they did not want to jeopardize the students' future, especially when they were so close to graduating, because of the significant personal cost to the student:

> I just told the clinical supervisor I would just give her a pass, and that's all. I didn't feel I wanted to end her nursing career on this one specialty, and I didn't feel like burdening that responsibility myself for making that decision about her.

This preceptor, like many others, did not want to be responsible for failing a student.

Some preceptors suggested that they are reluctant to fail students because of the amount of money involved in the university education. Other preceptors reported that, being in a caring profession, they are reluctant to fail students. Some fear the consequence of failing students because they interpret students' failure as their own failure or incompetence. As one preceptor commented:

> You don't want them to fail. I think part of it is looking at yourself too, because you are supposed to be getting this young nurse ready to step out into the professional world, and if she fails, maybe it's something you didn't do right.

Some preceptors suggested the preceptors are reluctant to fail students for fear of being labelled a "bad person" by other staff or students. Others suggested that students are given the benefit of the doubt because of complacency or laziness on the part of the preceptor. Some preceptors contended that preceptors pass students just to get them out of their way, leaving the students' deficits for the next person to deal with. One admitted

that she would not want to fail a student because of the extra workload involved in failing a student. Some preceptors may not have concrete evidence or documentation to validate their claims that a student is unsafe and therefore might find it difficult to fail the student. One participant suggested that some preceptors do not identify or deal with the students' problems early enough during the clinical placement and that failure to communicate concerns about a student to the instructor early enough means that no action can be taken, and thus the student ends up passing:

> I think some of them are not as eager to point out areas of weakness because it also looks like. . . "I haven't talked to the instructor about it ahead of time." So, if you have never talked to the instructor, but you feel a student is unsafe, how can you mark them when you really haven't gone about trying to help the student?

This particular preceptor acknowledged that instructors rely on preceptors' evidence and perceptions to justify the final course grade. Other preceptors have found it difficult to fail a student when they have not had enough time to observe the student in practice. Moreover, one preceptor commented that the clinical evaluation tool does not have enough objectives in the affective domain and that preceptors find it difficult to fail a student based on noncognitive skills such as poor attitude. Some preceptors also indicated that students are occasionally passed because of the close relationship between the student and preceptor or that the preceptor considers the student a "nice" person. Two preceptors believed that students are passed because of the current nursing shortage: "I think it's because we need nurses so bad, so quickly they are rushed through."

It is interesting that although the preceptors indicated their reluctance to fail borderline students, when they were asked whether they would want to work with these students upon graduation, most indicated that they would not. For instance, one preceptor

recommended that upon graduation her student not work on the unit because she was not suitable or competent enough for that particular unit at that time.

On a positive note, whereas the preceptors acknowledged the challenges that they face in making their final comments or deciding to either fail or pass a student, they also recognized and accepted their role as gatekeepers for the profession. As one preceptor affirmed, "But reality is also in my head that we need to be careful because of the nurses that are out there functioning below par, influencing the public impression about nursing in general."

Category 5: Strategies for Managing Unsafe Practice

This section discusses the strategies that preceptors use in dealing with students with unsafe practice. The preceptors were asked, "How do you think students with unsafe practices should be dealt with? Having experienced precepting such a student, what recommendations would you make to other preceptors?" The strategies that they recommended can be classified in three subcategories: (a) prevention of unsafe practice, (b) early identification of unsafe practice, and (c) dealing with unsafe practice.

Strategies for Preventing Unsafe Practice Before It Occurs

Almost all of the preceptors reported that they try as much as possible to prevent unsafe practice by becoming familiar with the course expectations, orienting students to the unit, and sharing expectations or setting clear expectations and goals with the students.

Becoming familiar with the course expectations. Some preceptors familiarize themselves with the course expectations prior to the clinical rotation to give them an idea of what the school expects from them as preceptors and determine the students' level of

competency. When students arrive on the units, the preceptors review documents such as the course expectations, students' learning objectives, the evaluation form, and the inventory list of the skills that students have learned in their previous clinical courses. This also assists them in determining the knowledge and skill level of their students.

Sharing expectations with students. Some preceptors set clear expectations for students that they share with them at the beginning of the rotation. This is important because having a clear understanding of the preceptors' expectations and goals assists students in adapting to the new environment and avoiding significant problems that may occur. As one preceptor commented:

> I try to nip it in the bud pretty quickly so as to prevent it. Upfront I tell students what I expect: "I expect you to know every med you give. I expect if you don't know something to ask me; we'll look it up. I don't expect you to know everything, so don't feel pressured. It's better for you to come to me and let me know," so that sort of thing. I try in the beginning to get some expectations.

Some preceptors also felt that it is important to review the students' own expectations to determine the appropriate levels of supervision and guidance or appropriate learning opportunities:

> In the beginning when they first come, I ask for all their skills they have worked on. Ask for their expectations and goals. I ask them to make a list too of what they hope to accomplish on the floor, some goals that they want, if it's IV administration, blood transfusion.

Knowing students' expectations and goals assisted preceptors in creating successful learning experiences for students and preventing conflict that may result from unrealistic goals. One preceptor emphasized the need for faculty members to ensure that the clinical setting to which they assign students will offer the experiences and appropriate learning opportunities necessary for them to meet their objectives.

Early Identification of Unsafe Practice

Students' unsafe practices are identified through direct observation, close monitoring of the student, feedback from colleagues, and, in some cases, additional information about the student from instructors. One preceptor reported that he needs to be attentive in working with students:

> I basically take this individual under my wing, and I basically watch them like a hawk because I don't want accidents to happen. . . . So I am very cognizant of the fact that these are people that have not had experience as [registered] nurses. . . . If the student makes a mistake, I feel I have a responsibility too, so I watch very carefully. My last student, she would be pouring meds for several weeks, and I would watch and would double check, and I would spot check and make her go over the medications and what they are and things like that.

The majority of the preceptors reported having identified hallmarks of unsafe practice very early in the rotation. Once they recognized unsafe practice, they became more vigilant to ensure that students did not compromise patient safety. As well, they consulted with colleagues who had worked with a student to confirm their observations. Some preceptors had had to contact the instructors to acquire additional information on the student to verify the level of competence and to determine whether this was a single incident or a pattern of behaviour:

> It became apparent very early on in the preceptorship that she was wasn't very safe, and just after the first two days I actually called the instructor to verify that this student was at year four and should be preceptored, because she really did seem to have very minimal skills, and her knowledge was very, very lacking.

The preceptors acknowledged that there are issues related to confidentiality of information, but they still felt that this information is important in selecting appropriate interventions to deal with such students:

> They had an idea he had a problem. . . . Well, from the beginning they don't come and say this student had that, because they might have improved. . . . They did

> indicate that in most placements he seems to be a little slower in catching up, . . . and that information at that point was to make us understand the nature of the problem.

Although this may have helped to validate the preceptor's feelings, the question remains, How much information should preceptors have about their students?

Other preceptors explained that once they confirm a pattern of behaviour, it is important for them to document their findings. They recommended that other preceptors document the details of specific incidents:

> It's a lot easier to recall if you have this happened on this date . . . and if you contact them right away after the first incident, and you say, "Okay, so-and-so made an error on this date. I just wanted to let you know. . . . I don't know if you have spoken to her about it or taken all the action about it." And then if something happens in the next shift, I might ... "well the student didn't come get me until like ten minutes later.". . . [Have] specific examples. . . . But I would keep documentation.

Proper documentation assisted this preceptor in giving accurate and specific feedback to the student. Providing detailed, specific feedback is important in managing students with unsafe practices because it identifies the preceptor's areas of concern about the student and assists in making specific recommendations for change.

Strategies for Dealing With Unsafe Practice

The preceptors acknowledged that, despite efforts to prevent unsafe practice, incidents can still occur that require careful management and involvement of the instructors or other resources. In this category, the following were some of the strategies that the preceptors recommended for dealing with unsafe practice: communicating the problem to the students; jointly setting up a plan of action; communicating the problem to the instructor; stopping the students and explaining the correct way of doing things; demonstrating new skills, followed by return demonstrations; constantly observing them

and allowing for gradual independence; encouraging students to practice skills; questioning the students based on reading assignments; creating a good learning environment; establishing good rapport with the students; being patient; giving timely, honest, and constructive feedback in private; getting input from colleagues; encouraging self-evaluation, maintaining a high standard of practice; seeking external help; and other remedial interventions.

Communicate the problem to the learner. The majority of the preceptors indicated that once they recognized unsafe practice, they communicated their concerns directly to the student. At this point they tried to ascertain whether the student was aware of the problem and could identify the source or factors that contributed to the unsafe behaviour. This is important because some students may not be aware of the problem, which can be very challenging for the preceptor. As one preceptor emphasized:

> They need to understand themselves. It's not so much us telling them it's unsafe; . . . they need to stop what they are doing, think about it, and then tell me why it's unsafe. And if they can verbalize it back to you why they shouldn't be doing it, then that's a big step.

This preceptor asserted that students who are able to identify their weakness are easier to deal with. Thereafter, she gives students a chance to respond and, if possible, decide how they could improve their performance.

Develop a plan of action. Most preceptors tried to address the problem as quickly as possible once they had identified unsafe practices. This was very important given the fact that students are in the clinical setting for a short period of time. Some preceptors also suggested that the next step would be to jointly set up and document a detailed action plan to offer the student opportunities to learn and improve. This plan, however, would depend on the nature and severity of the problem. For instance, for minor, straightforward

problems with limited impact on patients, they try to resolve them with the student before seeking external help. One preceptor explained:

> But if it was something that I can deal with—if they were supposed to get 1 mg of Ativan and she accidentally gives 2 mgs or was going to give 2 mg of Ativan—I would sit down and explain the basic 5Rs. And I would just say, . . . "You could have had an incident report filled out, and it could have been a much bigger mistake if it was a different type of medication."

Some preceptors also suggested that the approach would also depend partly on how receptive students are to constructive feedback.

Communicate the problem to the instructor. Most preceptors reported that they would immediately inform the instructor if the problem was repeated a second time or if something major occurred; otherwise, they would give the students time to improve. If there was no apparent improvement in the student's behaviour after a specified time, the preceptor would then consult the instructor. However, some preceptors felt that it is important to contact the instructor even for what appears to be a relatively minor concern to receive advice, guidance, and support. As one preceptor affirmed:

> I learned from experience that if you have any questions at all, things aren't quite coming together the right away, let the instructor know, so that way they can help out the student, assess the student too, and then from that go on.

It is interesting that one preceptor believed that instructors should not be involved in such problems. Instead, she insisted that preceptors should communicate with instructors only when students are doing well. This preceptor explained:

> I called their instructor and informed her that this is what's happening. . . . Her knowledge wasn't there; she was not willing to learn the stuff that needed to be learned for our type of unit. . . . So I had to get the instructor involved, and usually I don't like that. It's nice to have the instructor where you just give them updates on how well they are doing and that. But the instructor should not have to be involved.

Interrupt and explain the correct approach if a major mistake occurs. Several preceptors suggested if they recognized a major incident of unsafe practice that might jeopardize patients' or others' safety, they would immediately stop the student and take over whatever that student was doing. The preceptors encouraged their colleagues to explain the proper way of doing things to students and to give them time to improve. Most preceptors also initially demonstrated new skills and then gave students the opportunity to provide a return demonstration before they allowed them clinical independence. Similarly, others indicated that when students tell them that they are able to perform a procedure, they allow them to do so under close observation to ensure that they are doing it properly and then offer feedback accordingly. One preceptor remarked:

> When they do say they put in a Foley, I do participate and watch them do the first initial one. But if they do it wrong, then I will teach them from what I know and understand to maintain a good, sterile catheterization.

Observe constantly and allow for gradual clinical independence. The majority of the preceptors confirmed that once they identified unsafe behaviour, they initially monitor the students closely and then gradually allow them clinical independence. One preceptor who had an experience with a student with unsafe practice explained:

> And for a period of time when they start, [if] they seem to be unsafe to me, I'm constantly there. I have to closely watch what they are doing until they have proven they have gotten better and they have changed their ways. Then I can let them be more independent again.

Encourage students to practice skills. Some preceptors stressed the need to encourage students to continue practicing the skills once they have correctly performed a task. It is important that students master the skills because students who have successfully performed a task sometimes display a "been there, done that" attitude.

Question and give reading assignments. A few preceptors described how the process of challenging students through questioning and reading assignments. As one reported, "I question them on their knowledge and theory every day, and I ask them for research and make them look for stuff even though they think, okay, they know the stuff; . . . I keep on questioning." Another preceptor explained how she tries to create learning opportunities for students by letting the student work with the multidisciplinary team members on the unit.

Create an environment conducive to learning. The preceptors created a supportive or conducive learning environment for their students. As one preceptor asserted:

> I think it's also important to remember that, even though it's you who is precepting the student, especially in an environment like ours where we are doing team nursing, she is [also] working with all of the staff on the unit. And it's important to promote her positively to the rest of the staff. . . . If she [the preceptor] has a good relationship with them [staff], she [the student] will have an even better learning experience. . . . And if I'm talking negatively about her to my co-workers, this will lessen her chance of that learning experience.

This preceptor recognized that the relationship that the preceptor has with her colleagues influences how the other staff will handle the student. Thus, if the preceptor has a good working relationship with the other staff, they are likely to be receptive to the student. As well, preceptors were encouraged to have good rapport with their students to make them feel comfortable in approaching the preceptors with their concerns. Although they acknowledged that working with students with unsafe practice can be stressful, they still believed that it is important to be patient and support such students. In fact, one preceptor pointed out that it is essential that preceptors have a good rapport with the instructor as well.

Give timely, specific, honest, ongoing, and constructive feedback in private. The majority of the preceptors stressed the importance of giving timely, specific, honest, ongoing, and constructive feedback in private:

> If they are making a mistake, you tell them later. . . . You talk to them privately so the patient doesn't hear, because if the patients hear, they will lose confidence in [what] the student does; . . . they will be scared . . . [and will not] want to be taken care of by somebody who doesn't know. . . . But you don't want to show that. So that is very important for the student.

Some preceptors considered giving honest and constructive feedback to both students and instructors as critical. Preceptors need to be frank with both the student and the instructor and communicate the specific areas that need improvement. It is surprising that only one preceptor stressed the effectiveness of giving students immediate feedback. The preceptors noted that feedback is more effective if it is very specific and given as close in time to the event as possible. In addition, another preceptor noted that weekly feedback sessions had worked well for her. This same preceptor encouraged others to try to build on students' strengths. Most of the preceptors also stressed the importance of acquiring input from their colleagues as a second opinion on the student's performance.

Encourage self-evaluation. The preceptors also emphasized the necessity of self-evaluation:

> You need to look at yourself. . . [and] say, Am I seeing it right, or is it me? So you have to look at your own practice and see whether or not you are not imposing some sort of philosophy that you have on the student and take it that they are unsafe.

Some preceptors encouraged their colleagues to be receptive to other ways of doing things as long as students are able to explain the principles underlying their actions.

Allowance should be made for individual differences without justifying actions with "This is the way we do things here."

Maintain a high standard of practice. One preceptor stressed that it is important to maintain a high standard of practice especially while precepting students with unsafe practices. Although this preceptor acknowledged that there are intergenerational issues and that students may be undertaking a course of training that is very different from that of their preceptors, she believed that the staff must maintain their professional standard:

> Because we have different ways of training, different attitudes towards nursing, . . . I feel, as a preceptor, to make it work, . . . we have to have a high standard of professionalism. Like I always say, "Do I want to be looked after by them when I get sick?". . . When I think of the way I am working, I work hard, and I look after my patients well and safe, and I don't want to be looked after by the one who is kind of goofy.

Seek external help. Some preceptors also suggested that if the above actions have failed to resolve the situation and the preceptor is relatively new to the role, then he or she must seek guidance from a more experienced preceptor or colleague. As pointed out earlier, it is important that preceptors solicit help from colleagues or instructors as early as possible when they realize that they cannot handle a situation or that they require more information about the student to confirm a pattern of behaviour.

Use remedial interventions and make the decision to fail. The preceptors recommended the following interventions in cases in which the above strategies do not resolve the problem: changing the environment or preceptor, reducing a student's patient load, reviewing areas of practice with the instructor, requiring an additional/repeat practicum, and, counselling the student to discontinue the program. Regarding a change of environment, some preceptors suggested that, if possible, the student be placed on a

different unit or with a different preceptor. A few preceptors proposed the option of reducing the student's patient assignment:

> I felt if she was on a unit where the patients were far more stable with less number of demands on the nurse's attention, she would do better. . . . [Or] if she had a smaller patient assignment that wasn't as heavy, she could probably cope a lot better.

Some of the preceptors recommended that once unsafe practice has been recognized, arrangements be made for the students to review with the instructor the specific areas that they need to practice safely. Then they must be tested before being allowed back to practice. Most preceptors, however, suggested that the students be given a chance to repeat the practicum or be granted an extension of the practicum if they are struggling. However, the majority of the preceptors recommended that if the problem of unsafe practice cannot be resolved, for the sake of patients' safety, the students should be failed or counselled to discontinue the program.

Summary

This chapter has highlighted the challenges that preceptors face in precepting students with unsafe practices. The preceptors indicated that they identify hallmarks of unsafe practice early in the placement through vigilant observations of students while they are performing patient care activities. These were mainly related to the inability to demonstrate knowledge and skills, poor communication skills, and unprofessional behaviours. The most common behaviours that alert preceptors to the need for intervention are mainly students' lack of knowledge and poor skill performance.

One of the most striking findings was that medication errors are common among students. The preceptors felt that students are not adequately prepared for their

preceptorship experience. Attitudinal problems that are particularly frustrating and challenging for preceptors are related to defensiveness, an unenthusiastic attitude toward learning, and a "know-it-all" attitude. They perceived behaviour such as dishonesty, negligence, and crying as unprofessional. The preceptors contended that the university nursing program place more emphasis on theory than on practice and that students are sometimes unsafe because they have not had enough time to practice the required clinical skills training. Thus, the preceptors stressed the need for increasing the number of clinical hours to facilitate additional experience in basic skills. They also identified personal and professional stress as a factor that contributes to unsafe practice.

A majority of the preceptors acknowledged that students sometimes pass their clinical practicum without having gained sufficient clinical experience, and they cited several reasons for 'failure to fail' students, including a lack of experience or confidence in the preceptor role, difficulty failing the student close to the date of graduation because of the significant personal cost to the student, not wanting to jeopardize the student's career, and not wanting to be responsible for failing a student. The preceptors reported experiencing a variety of feelings, including relief, anxiety, self-doubt, and frustration as they proceed through the process of evaluating a student with unsafe practices. They also highlighted the important role of instructors in such situations.

The preceptors recommended strategies for dealing with students with unsafe practices, which were classified under three subcategories: strategies for prevention of unsafe practice, early identification of unsafe practices, and dealing with unsafe practice, including remedial interventions.

Overall, the findings of this study reveal that undergraduate nursing preceptors do encounter students who display unsafe practices during placements. The preceptors described precepting such students as a demanding, stressful, and challenging process of remedial skill development rather than allowing them to provide the finishing touches prior to graduation or an exciting learning opportunity. They cited the amount of time involved in preparation, supervision, and evaluation as the most challenging and stressful. The preceptors believed that early identification and intervention of unsafe practice is critical in managing students who display unsafe practices in the clinical setting.

CHAPTER 5:

DISCUSSION OF FINDINGS

The discussion of the findings of this study are presented in this chapter under the following major sections: (a) an overview of the process of precepting a student who engages in unsafe practice; (b) hallmarks of unsafe practice, (c) factors that contribute to unsafe practice, (d) preceptors' perceptions and feelings, (e) grading issues, and (f) strategies for managing unsafe practice.

The Process of Precepting a Student with Unsafe Practice: An Overview

The study explored the social psychological processes involved in precepting a student with unsafe practice and identified effective management and coping strategies that preceptors use. The data analysis revealed a multifaceted process that showed that "promoting student learning while preserving patient safety" is the core variable or main process involved in precepting a student with unsafe practice.

Figure 2 shows the five major variables, the processes that preceptors use to manage students with unsafe practices, the preceptorship triad and the core variable. The five major categories represent the processes preceptors experienced or used to manage students engaging in unsafe practice. Preceptorship is a triad that comprises the preceptor, the student/preceptee, and the faculty or instructor. Each member of this triad plays a vital role in the success of the preceptorship experience. Both preceptors and students need support and guidance from instructors, who must respond immediately to concerns that preceptors or students raise (Myrick & Yonge, 2005). Therefore, if instructors do not make themselves available to preceptors, the preceptors will not feel supported. In

addition to support, preceptors need concrete guidelines and assistance with the process of dealing with students whom they do not feel comfortable in passing.

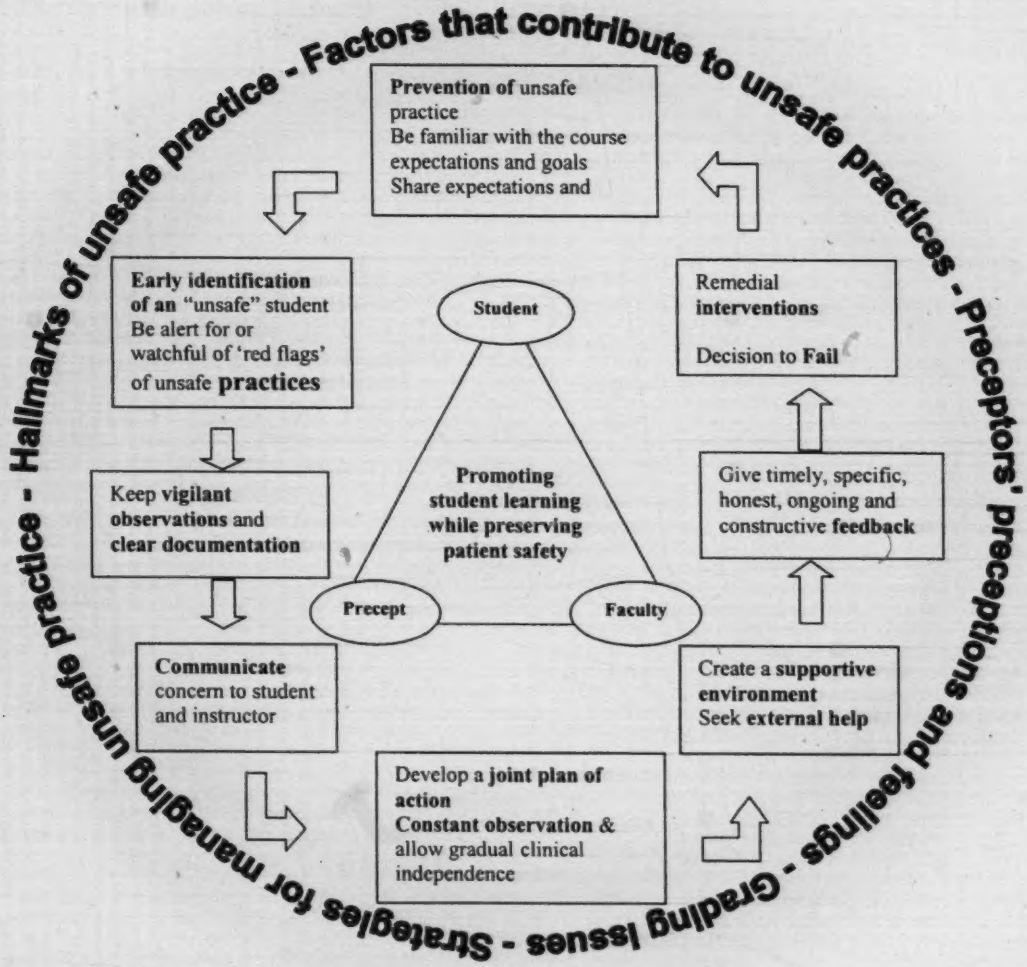
Hallmarks of unsafe practice - Factors that contribute to unsafe practices - Preceptors' perceptions and feelings - Grading issues - Strategies for managing unsafe practice
Prevention of unsafe practice
Be familiar with the course expectations and goals
Share expectations and
Early identification of an "unsafe" student
Be alert for or watchful of 'red flags' of unsafe practices
Keep vigilant observations and clear documentation
Communicate concern to student and instructor
Develop a joint plan of action
Constant observation & allow gradual clinical independence
Create a supportive environment
Seek external help
Give timely, specific, honest, ongoing and constructive feedback
Remedial interventions
Decision to Fail
Student
Promoting student learning while preserving patient safety
Precept
Faculty

Figure 2. Precepting a student with unsafe practice: The process.

Preceptors need to know how to handle "unsafe" or marginal students. It is important for instructors to assess the type and frequency of contact that the preceptor requires and implement mechanisms to meet these needs. The results of this study reveal that some preceptors did not feel supported at one point or another during the experience. Therefore, it is the responsibility of educational institutions to provide such support. This is important because preceptors who perceive instructors as uncommunicative or disinterested may be reluctant to continue precepting or feel that the university is just 'dumping' students on them. Preceptors need support to function effectively in this demanding role.

Being a preceptor means paying attention not only to the patient and one's ordinary work as a nurse, but also to the student (Öhrling & Hallberg, 2000). In busy clinical settings, however, patient care is given priority over student learning (Coates & Gromely, 1997; Corlett, 2000). It is important at the beginning of the preceptorship experience for preceptors to become familiar with course expectations and goals, share expectations with students, and verify the student's level of knowledge, competence, and, most important, sense of responsibility. The researcher identified the main concern or core variable in this study as "promoting student learning while preserving patient safety." The preceptors who participated in this study recognized the competing demands of encouraging student independence and being professionally obliged to ensure safe and competent practice. They also reported that they found it hard and challenging to balance the need to closely supervise students with the need to allow them clinical independence. However, the majority of the preceptors indicated that they try as much as possible to prevent unsafe practice from occurring by being alert to hallmarks of unsafe practice.

Despite these preceptors' efforts to prevent unsafe practices, occasionally an incident occurred that required careful management and, at times, the involvement of the instructor or other external resources. Unsafe practices were identified early in the rotation through close observation of 'red flags.' Once the preceptors recognized these signs, they consulted colleagues and instructors to validate their observations, communicated the problem to the student, and gave the student an opportunity to improve. If there was no improvement by midterm, the preceptors contacted the instructor, and in some cases a joint meeting was scheduled to decide on the proper course of action. A learning contract was then developed to give the student an opportunity to improve.

Other important mechanisms that these preceptors used in the process of managing students with unsafe practices included, but were not limited to, creating a good learning environment, observing vigilantly and documenting clearly, and providing opportunities for remediation. If there was no improvement in performance after a specified period of time, they made recommendations such as repeating the placement, reviewed specific content areas with the instructor, or, if appropriate, counselled the student out of the program and assigned a failing grade. At this stage the guiding principle for all involved was the safety of the patient, a factor that must take precedence over all other considerations (Myrick & Yonge, 2005). It is reassuring, however, to hear that in most cases the students improved by the time that the rotation was completed with guidance and support from preceptors and instructors.

Hallmarks of Unsafe Practice

The results of this study indicate that the first process in managing students with unsafe practice is the identification of unsafe practices. To do so, the preceptors noted that they initially had to recognize the 'red flags' or hallmarks of unsafe clinical performance. Although these signs could occur at any stage in the preceptorship experience, the majority of the preceptors in this study reported that they occurred early. As one preceptor commented, "Fairly soon, within the first few days of having the student on the unit, I could tell that she had the potential to be unsafe." Once they identified unsafe practice, some of the preceptors usually gave students a week or two to become familiar and comfortable with the routines on the unit before addressing the problem or asking for external assistance. These findings are consistent with the findings from previous studies (Duffy, 2004; Hrobsky & Kersbergen, 2002; Lankshear, 1990) in which preceptors were aware of problems from the onset of the rotation but gave the students time to settle down. Scanlan et al. (2001) found that it can take two to three weeks to recognize poor performance.

However, Langlois and Thach (2000b) cautioned that at times the 'wait and see' approach of potential issues can be costly and ineffective, especially in short clinical experiences. They asserted that an excuse for one week may lead to another, and before one realizes it, either the problem has grown or it is near the end of the clinical experience, and there is no time to intervene. Therefore, they recommended an early intervention based on a 'SOAP' approach, a format that encourages specific, constructive feedback to the student, as well as a plan for correction of problem and remediation, including review with students (Hicks, et al. 2005).

Behaviour or attitudes that warned the preceptors to be more vigilant or watchful over the student were related mainly to the inability to demonstrate knowledge and skills, poor communication skills, and unprofessional behaviour. Examples of students' behaviour that the preceptors in this study identified as unsafe included demonstration of a lack of basic knowledge and poor skill performance, difficulty in organizing basic patient care activities, failure to critically question their own practice and lack of insight into the possibility of making an error, inability to follow instructions, and failure to ask questions. Other warning signs of unsafe practice cited were related to a poor work ethic, lack of confidence or extreme nervousness, dishonesty, and not admitting to their own mistakes; as well as attitudinal problems, such as being overconfident, defensive, or unreceptive to feedback, and an unenthusiastic attitude toward learning or work. These findings are similar to behaviour that the literature identified as unsafe or unprofessional in nursing (Duffy, 2004; Hrobsky & Kersbergen, 2002; Ritmann & Osburn, 1995) and other health professions (Hayes, et al., 1999; Hendrickson & Kleffner, 2005; Wolfe-Burke, 2005). For instance, in Hrobsky and Kersbergen's study, the preceptors identified such behaviours as not asking questions, having an unenthusiastic attitude toward nursing, and demonstrating unsatisfactory skill performance as red flags for potential poor performance. Similarly, Wolfe-Burke conducted a study with physical therapist clinical instructors to identify behaviour as appropriate and inappropriate and compared these behaviours with those identified in the literature. Like the preceptors in this study, Wollf-Burke's participants identified having an attitude, demonstrating lack of interest, communicating poorly, and being unprofessional as inappropriate behaviour.

In a final practicum students are expected to perform all role functions and to assume an increasingly larger patient load in a more proficient, organized, skilful, and independent manner (Hayes, 1994; Hill et al., 1999). Similarly, the preceptors in this study expected final-year students to be competent in most of the basic nursing skills but found that some students still lacked these skills. The most common behaviour that alerted the preceptors in this study to the need to intervene was primarily related to the student's lack of knowledge and poor skill performance. It is therefore possible for some students to become registered nurses without mastering certain basic skills. In fact, one preceptor affirmed this observation with an example of a BScN graduate who did not know how to give an injection. This concurred with the findings in a study in which students were concerned that they had not gained sufficient experience in a number of basic skills such as taking blood pressure or giving injections, which raised concerns regarding the possibility of some students' qualifying for registration without achieving an acceptable level of competency (Dolan, 2003).

The preceptors in this study believed that students are unsafe because they lack the knowledge base to carry out required skills. Students need to possess a sound knowledge base to guide them in clinical decision making and their actions to provide safe and competent care (Myrick, 1998). Theoretical knowledge helps students to understand patient care situations; organize, analyze, and interpret data that they may encounter; and plan and implement care purposefully and proactively (Myrick, 1998; Raudonis & Acton, 1997). However, preceptors need to be realistic about their expectations of students in relation to both clinical knowledge and practical skills. It is possible that some preceptors have too high expectations of final-year students. Students

enter the preceptorship experience with varying levels of knowledge and skills and different types of clinical experiences (Langlois & Thach, 2000a; Myrick & Yonge, 2005; Oermann & Garvin, 2002). Although some students may meet these expectations, others may need more time to develop their knowledge and skills. Therefore, rather than viewing a student as someone who is not competent for practice, preceptors must instead plan patient assignments and learning activities that will enable students to develop the competencies that they are lacking (Bick, 2000; Oermann & Garvin, 2002).

One of the most striking findings in this study was the number of medication errors that students commonly make and that three quarters of the preceptors reported. They observed that some students are not able to calculate drug doses accurately. One preceptor attributed this lack of knowledge and skill to the fact that nursing students are not taught basic courses such as pharmacology that she felt are fundamental to drug administration and nursing. This finding is consistent with those of previous research (Bullock & Manias, 2002; Clancy, McVicar & Bird, 2000; King, 2004). Clancy et al. found that 98% of the nurses and students who were surveyed expressed a need for more education in the biological sciences to prepare them for practice. Similarly, in a recent study in the UK, Kings (2004) revealed that nurses are dissatisfied with pharmacology education and yet recognize the need for pharmacology knowledge. Bullock and Manias (2002) explored lecturers' perceptions and expectations of teaching and learning pharmacology in preregistration nursing courses in Australia. The participants emphasized the importance of pharmacology in the undergraduate nursing curriculum. The findings reveal significant variability in the levels and amount of pharmacology taught to students, depending on each institution's priority and that students experienced

difficulties relating pharmacology theory to practice. Bullock and Manias concluded that nurses who have a strong knowledge base in pharmacology are better prepared to fulfill their roles in the management of patients' drug therapies and medication education. For example, to administer an intramuscular injection, students need to understand the principles of asepsis, anatomy, physiology, physics, and pharmacology (Infante, 1985). To ensure safe administration of medications, students are expected to follow the five 'rights' of medication administration: the right medication, the right dose, the right client, the right route, and the right time. Calculating drug doses correctly is an essential skill for nurses that requires basic math skills. They must be able to add, subtract, multiply, and divide whole numbers and fractions, but this was not the case with some students.

Several researchers have confirmed that nursing students have poor mathematical and medication calculation skills (Blais & Bath, 1992; Bliss-Holtz, 1994; Grandell-Niemi, Hupli, & Leino-Kilpi, 2001; Polifroni, et al., 2005). Blais and Bath (1992) examined nursing students' drug calculation skills and identified three areas of deficiencies: mathematical, conceptual, and measurement. More recently, Grandell-Niemi et al. found that students' mathematical skills were inadequate and that one fifth of the students failed to pass the medication calculation test. The students reported that they found it difficult to learn mathematics and medication calculation skills, and the researchers found that the introductory course on medication calculation was uninteresting and poorly organized. Polifroni et al. confirmed that new and recent graduates of schools of nursing have limited mathematical skills for medication administration. Nursing students, like nurses, need to calculate patients' drug doses correctly, because failure to do so could have potentially fatal consequences. Polifroni

et al. (2005) suggested that to avoid medication errors in practice, all nurses must regularly take examinations in mathematics skills. Similarly, Grandell-Niemi et al. suggested that the medication dosage calculation content of courses should be integrated throughout the undergraduate nursing curriculum and within the clinical nursing courses because the skills require refreshing at regular intervals (Blais & Bath, 1992). The findings from this study and those of previous studies suggest that there is a theory gap in the pharmacology education of nurses and that this may be a contributing factor to the high incidences of medication errors among students. Effective preparation is essential during training if students are to develop the necessary skills to be able to administer medications safely. Therefore, this omission of pharmacology in the current nursing curriculum certainly requires further exploration by nursing faculty and administrators.

Organizational ability and priority setting are essential skills for professional practice (Gaberson & Oermann, 1999; Myrick & Yonge, 2005); therefore, students' lack of organizational and time-management skills is a cause of concern for preceptors. Gaberson and Oermann (1999) explained that nurses need these skills to be able to set priorities, manage conflicting expectations, and sequence their work to be able to function effectively. Preceptors expect students in their final practicum to be more organized and have better time-management skills, which is not evident in all students. During the interviews some preceptors described students as "very sloppy," and others gave examples of incidents in which students had difficulties with organizing and completing their patient care activities or working in a timely manner. Similar concerns have been raised in previous studies (Myrick, 2002; Lowry, Timms & Underwood, 2000). Lowry et al. for instance, identified a lack of organizational and time-management

skills among students. However, these are skills that are difficult to teach in university but that are better learned through experience in the clinical setting (Bick, 2000). In support of this view, one preceptor in this study commented, "I think mostly when they come to our unit they should be learning more like organizational skills, how to take care of more patients."

The kind of questions that students ask helps the preceptor to determine their level of competence. With this knowledge the preceptor can plan appropriate learning experiences and judge when and how to provide backup to safeguard patients' safety. The preceptors in this study therefore preferred students who ask questions to those who do not and then make mistakes. However, it is important for preceptors to realize that a student with a weak knowledge base may not feel comfortable in asking or answering questions for fear of not knowing the correct answers (Benzie, 1998). Other behaviour that was of great concern and frustration to the preceptors was related to students' inability to follow instructions, because such students cannot be trusted with patient safety.

Particularly frustrating and challenging attitudinal problems that alerted the preceptors to the possibility of unsafe practice included acute defensiveness, an unenthusiastic attitude toward learning or work, and a "cocky, know-it-all" attitude. These findings support what has been reported in nursing (Duffy, 2004; Hrobsky & Kersbergen, 2002) and other health professional literature (Hayes et al., 1999; Hendrickson & Kleffner, 2002; Hills et al., 1999; Verma & Patterson, 1999; Wolff-Burke, 2005). The preceptors in this study identified students who are unreceptive to feedback as the most difficult to teach and manage. For example, one preceptor gave a

detailed account of how one of her students reacted after she had given the final evaluation. The student had cried and told her that if she failed her final practicum, it would be the preceptor's fault because she had received honours in all of her previous courses. This incident demonstrates that through frustration and anger some students may undermine the preceptor or project their failure onto the preceptor.

Similarly, other studies have shown that when students were faced with difficulties in clinical placement, they reacted in anger, frustration, disappointment, and shock (Burgess, Phillips & Skinner, 1998; Duffy, 2004). These findings also confirm that students with high expectations of their own performance can exhibit difficult behaviour if they fail to achieve their expectations (Hendrickson & Kleffner, 2002; Rees & Shepherd, 2005). Such behaviour has been attributed to students' previous academic success, overconfidence, and previous lack of good-quality feedback (Rees & Shepherd, 2005). Moreover, in some cases students who are not meeting the clinical objectives may be unaware of their deficits or unwilling to accept critical or negative feedback. Because of their lack of insight, such students tend to have very high, although inaccurate, estimates of their abilities, which can be very challenging for most preceptors. Therefore, it is important that feedback be given cautiously and in an advisory rather than an accusatory manner; otherwise the student may become dissatisfied with the evaluation process and lose trust in the value of self-assessment (Rees & Shepherd, 2005).

In Hills et al.'s (1999) study, preceptors identified the 'unmotivated student' as the most challenging. Similarly, the preceptors in this study expressed concerns about students who do not seem to be interested in learning, either because they feel that they have accomplished all the tasks or they are not interested in nursing. However, students

must be assisted in practicing what they are learning and be made aware that performing a task once is not enough to become proficient. In fact, it is important for students to inform the preceptor of their learning needs so that the preceptor can organize specific learning opportunities for them. However, preceptors must also realize that sometimes acute defensiveness, lack of motivation, and a "know-it-all" attitude may be the behavioural manifestations of underlying learning deficiencies or medical problems (Hendrickson & Kleffner, 2002).

The preceptors in this study also described various behaviours that were identified as unprofessional. For example, when students demonstrated dishonesty, lack of confidence, or extreme nervousness, they were identified as being unprofessional and unsafe. Honesty and integrity are values that are expected of all professional nurses, as well as students (CNA, 2002). Dishonesty includes lying, cheating, plagiarizing, altering or forging records, falsely representing oneself, and knowingly assisting another person to commit a dishonest act (Gaberson, 1997; Gaberson & Oermann, 1999). Dishonest behaviour such as lying violates both legal and ethical standards of nursing practice. Dishonesty violates the ethical principle of veracity or truth telling, and telling the truth in any personal or professional communication is a moral and ethical requirement (Cherry & Jacob, 2002). The development of trust between the preceptor and student requires truthful interaction and meaningful communication between them (Cherry & Jacob, 2002; Gaberson & Oermann, 1999). Clinical dishonesty behaviours in the clinical setting can also jeopardize patient safety if students fail to report errors.

Gaberson and Oermann (1999) further suggested that clinical dishonesty among students is usually a result of one or more of the following factors: competition for good

grades in clinical courses, emphasis on perfection in that clinical educators communicate to students that good nurses do not make mistakes, poor role modeling, and impaired moral development. In fact, because of its potentially devastating impact on patients, students, faculty-student relationship, and the educational program, prevention of clinical cheating or lying should be a priority for preceptors and nursing faculty (Gaberson, 1997; Gaberson & Oermann, 1999; Hoyer, Booth, Spelman & Richardson, 1991). It is therefore crucial for preceptors to be exemplary in their own moral behaviour in practice and teaching-learning relationships because students process information through casual observations and expectations as well as interactions with preceptors. Hoyer et al. (1991) and Gaberson and Oermann (1999) also suggested that nursing curricula must reflect the values of the profession and be structured to nurture the moral development of students.

According to the nursing literature, most students experience some anxiety about clinical learning activities (Arnold & Nieswiadomy, 1997; Beck, 1993; Blainey, 1980; Gaberson & Oermann, 1999; Kleehammer, Hart, & Keck, 1990). A student who lacks confidence in performing a skill will normally demonstrate extreme nervousness. In addition, new learning situations frequently result in significant initial nervousness and anxiety (Langlois & Thach, 2000b). Mild or moderate anxiety can serve as a positive motivating influence and enhance learning, whereas extreme nervousness or high levels of anxiety can impair concentration and the ability to receive and process information (Meisenhelder, 1987) and thus interfere with student learning or clinical performance (Arnold & Nieswiadomy, 1997; Blainey, 1980; Gaberson & Oermann, 1999; Langlois & Thach, 2000b; Nolan, 1998). Similarly, the preceptors in this study identified anxiety or nervousness as one of the hallmarks of unsafe practice.

Specific sources of students' anxiety within the clinical setting include fear of making a mistake that would harm the patient (Kleehammer, Hart, & Keck, 1990), interacting with faculty and other health care professionals, fear of criticisms, the changing nature of patient conditions, a lack of knowledge and skills to provide care to patients and families in the clinical setting, and difficult patients (Arnold & Nieswiadomy, 1997; Beck, 1993a; Blainey, 1980; Kleehammer et al., 1990; Gaberson & Oermann, 1999). Kleenhammer et al. examined the perceptions of anxiety-provoking situations in the clinical setting with junior and senior nursing students in a baccalaureate program. The findings reveal that initial clinical experiences on a unit and the fear of making mistakes are the main causes of anxiety among students. Beck conducted a phenomenological study to explore the lived experience of nursing students' first clinical involvement. Emerging themes included: experiencing prevailing anxiety, feeling abandoned, encountering reality shock, envisioning self as incompetent, doubting choices, and experiencing uplifting consequences. Preceptors must realize that with each unsuccessful attempt at a procedure, the student's anxiety level increases, which may further hinder performance (Valiga & Streubert, 1998).

Previous findings and the findings from this study suggest that faculty members or preceptors need to create ways to reduce anxiety and foster confidence and positive attitudes to learning in students (Blainey, 1980; Gaberson & Oermann, 1999). For example, preceptors can reduce students' anxiety by creating a climate for learning in which all behaviours and knowledge application are not expected to be perfect (Blainey, 1980). A structured preconference can also help to identify students' fears and reduce their anxiety to a manageable level (Arnold & Niewiadomy, 1997; Gaberson & Oermann,

1999). However, Arnold and Niewiadomy (1997) cautioned that for this strategy to be effective, students must be assured that revealing their fears and doubts will not influence the evaluation of their performance. Students should have opportunities to reflect on and verbalize both negative and positive feelings about their clinical experiences (Beck, 1993a).

The participants in this study considered demonstrating crying, negligence, and gossiping as evidence of poor work ethics and unprofessional behaviour. The participants in Wollfe-Burke's (2005) study also described behaviour such as crying and lack of confidence as signs of immaturity and lack of professionalism. Cherry and Jacob (2002) defined *negligence* as "the failure to act in a reasonable and prudent manner" (p.167). Negligence may involve carelessness such as not checking a patient's arm band or observing the five rights, which can result in medication errors. The most common negligent acts in nursing include making medication errors; failing to monitor patients, which thereby results in injury; failing to report significant findings; failing to exercise reasonable judgment; and failing to follow the agency's policies and procedures (Cherry & Jacob, 2002; Perry & Potter, 2001). The preceptors in this study reported that some students have engaged in negligent acts that they believed were red flags for unsafe practice. As one preceptor related, "When a patient is acute and they just kind of ignore it and hope it will go away, I have seen that; or they would rather sit on the desk and talk." Another one stated, "Things like not watching the patient closely if they are not stable on their feet and in the shower, and they turn their back and the patient falls. Something like that would be unsafe behaviours." Being negligent is an example of malpractice and unethical practice. Nursing students, like registered nurses, are expected to provide safe,

competent, and ethical care to their clients (CNA, 2002). The claim of negligence is based on the principle that students, like registered nurses, are expected to conduct themselves in a reasonable and prudent manner. Therefore, a student who does not meet acceptable standards of practice or who performs duties in a careless manner runs the risk of being found negligent (Perry & Potter, 2001). Similarly, gossiping about others while on duty violates nursing's ethical codes and practice standards. Gossiping may also damage interpersonal relationships within the work environment.

Other behaviour that the participants identified as unprofessional is related to demonstrating poor communication or interpersonal skills (such as being argumentative), rolling eyes and sighing in front of patients, chewing gum, and yawning. Similar findings have been reported in other health professional education programs. For instance, in Wollfe-Burke's (2005) study, physical therapist clinical instructors identified inappropriate language, gestures, and verbal communication such as arguing as evidence of poor communication skills. Preceptors must realize, however, that student communication or interpersonal skills may be limited at the beginning of the clinical experience and that these skills develop gradually with instruction or preceptor guidance.

Factors That Contribute to Unsafe Practice

The results of this study reveal a variety of factors that contribute to students' unsafe practice that singly or in conjunction with other factors interfere with student learning in the clinical setting. These include, but are not limited to (a) emphasis on theory rather than clinical practice, (b) short clinical placements or lack of time to practice skills, (c) programs or previous educational preparation, (d) personal and professional stress, (e) the clinical learning environment, and (f) language barriers.

Emphasis on Theory Rather Than Clinical Practice

The preceptors believed that students are unsafe if they do not have enough time to practice their clinical skills. This is congruent with Duffy's (2004) findings that preceptors believe that the university nursing program places too much emphasis on theoretical assignments rather than clinical practice. Students are expected to write theoretical assignments during their practicum, and some students are therefore overly concerned with their theoretical assignments and give priority to writing these assignments or studying for tests while in clinical placements. This is most likely because students realize that there is a far greater chance that they will fail theory than practice (Calman et al., 2002; Duffy, 2004; Norman et al., 2002; White, Riley, Davies & Twinn, 1994). In White et al.'s (1994) study, students reported that it is virtually impossible to fail the clinical component of the course. However, students must be made aware that clinical practice hours are to be spent either in practice or in contact with patients and that theoretical assignment must not be written during practice hours. The concern that nursing students are given too many theoretical assignments during their final practicum has not been previously raised in the nursing literature. It is therefore an issue that requires further exploration and consideration, as well as whether students in other health professional programs are expected to write theoretical assignments during their final clinical or field placements.

Short Clinical Placements or Lack of Time to Practice Skills

Although the preceptors in this study appreciated the sound theoretical and broad research knowledge base that the university provides students, they still believed that students need to be given enough time for clinical experience to acquire the skills

required of a competent graduate nurse. One preceptor commented, "To me they are not getting enough hands-on experience. . . . They know the theory, . . . but patients are lying in bed in pain and need something and don't care about Roy's model." As stated earlier, most of the preceptors believe that the university program does not adequately prepare students to become bedside nurses. Their focus in voicing this concern related primarily to the technical aspect of nursing practice and associated nursing practice with mastery of technical or practical skills. However, one of the major aims of moving nursing education away from an apprentice style to education within tertiary institutions is to expose students to research-based education (Clark, Maben, & Jones, 1997). Focusing on graduate skills, it is thought, will allow students to adopt a more critical, analytical approach to the delivery of nursing care and to enhance care through applying research in practice (Fitzpatrick, White, & Roberts, 1993; Wheeler, Cross, & Anthony, 2000). Moreover, if students are to assume the role of competent professionals upon graduation, possessing the ability to think critically and creatively will ultimately improve the quality of patient care (Fitzpatrick et al., 1993; Myrick, 2002; Wheeler, et al., 2000). Nevertheless, although a sound, academic foundation and a broad research base for nursing are essential for professional practice, consideration the balance between theory and practice still needs to be considered. Because nursing is a practice-based discipline, it is important that nursing education continue to have a strong practical component despite its full integration into higher-education institutions.

Programs

The preceptors in this study were concerned about the kinds of programs and teaching approaches that the university currently offers. For instance, one preceptor

commented that the context based learning (CBL) approach used in the university nursing program as a teaching method does not offer students a good knowledge base or practical skills. Some preceptors also believed that students learn more practical skills during summer holidays when they work as employed nursing students (UNEs) than they do in all the time that they spent on their previous clinical courses at the university. Greenberger, Reches, and Riba (2005) found that being employed in a health care facility seemed to have a positive impact on students' perceived competence level in some basic skills such as reading vital signs. One preceptor raised a concern about after-degree students: that many nurses do not support the program because it does not offer them a good theoretical background and that they are not assigned enough time for clinical experience and therefore struggle in the clinical setting. However, the fact that the number of clinical hours has not been found to be a key factor in successful clinical experience, lengthening the students' clinical rotation in and of itself may not be the solution to improving skills. This is especially true for adult academically educated learners who pursue nursing to obtain a second degree (Greenberger et al., 2005; Pelletier, 1995). Pelletier also evaluated how well the tertiary education experience prepares students in terms of their ability to handle common technological equipment such as infusion control devices and pumps. Factors such as age and previous work experience contribute significantly to the comfort in handling technical equipment in clinical practice. Pelletier (1995) concluded that older students are more likely to gain confidence on the unit quickly, probably because of the previous professional experience that older students bring to the program. These experiences in turn foster self-confidence,

motivation, and assertiveness, which enable them to make better use of their clinical experience. These are some of the issues that require further exploration.

Most of the preceptors in this study attributed the students' lack of skills to the fact that they do not acquire enough practical skills in the university nursing program. Most of the preceptors in this study were diploma prepared and compared the current students' preparation with either their training or earlier nursing education programs. They believed that, because their training included more practical clinical experiences, by the time they qualified for the diploma, they were able to competently perform most of the basic nursing procedures. As one preceptor commented, "It was a lot different when I trained. . . . After the first year we had regular patient assignment and worked as staff, so we had a lot of experience. By the time I graduated I pretty well had covered everything." This view supports the findings from other studies (Greenberger et al., 2005; Halloway, 1999) that graduates of diploma programs perceive that they themselves are more competent than graduates of tertiary or university programs

Bick (2000) acknowledged that students in tertiary programs spend less time working in the clinical setting than they did in previous training programs (i.e., diploma, apprenticeship, etc.). Certainly, if this is so, then they are likely to enter their preceptorship experience and even to qualify for registration with less clinical experience and some clinical skill deficits. Consequently, the preceptors in this study suggested longer clinical placements for students. However, as pointed out earlier, no relationship has been found between the length of the clinical experience and the clinical performance (Battersby & Hemmings, 1991). In fact, Battersby and Hemmings found that students with the fewest clinical hours during their nursing program performed better initially

upon graduation than did those with more clinical hours. Gaberson and Oermann (1999) agreed and pointed out that "the length of time spent in clinical activities is no guarantee of the amount of quality of learning that results" (p. 8). Therefore, this issue may require further exploration and consideration. In the meantime, given the limited time that students spend in clinical placement, there is a need for both students and preceptors to make the best use of their time.

As reported earlier, the preceptors in this study believed that students are not adequately prepared for the preceptorship experience. Preceptors, students, and faculty have previously expressed similar concerns, according to the nursing literature (Souers, 2002; Yonge & Myrick, 2004). Recently, Yonge and Myrick investigated nursing students and their preceptors' views of preparation in relation to a 340-hour preceptorship course. The results of a mail survey revealed that about half of the students and preceptors felt that they were not well prepared for the preceptorship experience. The students complained that the pre-preceptor course that they took was useless and unrealistic, partly because it was more of a self-directed form of learning (Yonge & Myrick, 2004). This finding suggests a need for a comprehensive or formalized course in preceptorship, with which Souers (2002) concurred. It must not be assumed that all final-year students are ready to begin the preceptorship experience. Selecting suitable students for preceptorship is crucial to patient safety, student achievement of course objectives, and minimization of the burden on preceptors and clinical instructor (Ellerton, 2003; Yonge et al., 2002a, 2002b).

Personal and Professional Stress

Personal and professional stress is another factor that the preceptors believed contributes to unsafe practice, mainly with regard to lifestyle. For example, the preceptors acknowledged that some students work while studying either to pay for their education or to maintain their families. This means that they may not get enough rest to function optimally. Although individual sleep needs vary, most adults need about eight hours of sleep per day for optimal functioning. Getting less sleep undermines mental abilities (Lamberg, 2002); therefore, if students do not have enough time to rest, they are likely to lose concentration and make errors during clinical practice.

The preceptors identified other potential factors in poor performance or unsafe practice, including inadequate educational preparation, distraction because of the poor health of a family member, and underlying personal medical conditions. These findings concur with those in the nursing (Scanlan et al., 2001; Timmins & Kalszer, 2002; Yonge et al., 2002a) and other health professional literature (Cleland, Alnord, & Chesser, 2005; Hendrickson & Kleffner, 2002).

In Timmins and Kalszer's (2002) study, 99% of the nursing students identified the financial constraints of enrolment in the program as a major source of stress. Similarly, Sayer, Chaput De Saintonge, Evans, and Wood (2002) found financial, domestic, and emotional problems among the factors that contribute to academic failure. An understanding of the stress that students may experience during their practicum may enable preceptors to provide them with the necessary assistance. These findings suggest the need for support from both preceptors and instructors to help students cope with the stresses that they experience during their preceptorship experience. However, because of

the need for confidentiality, exploring these nonacademic issues may be difficult for preceptors. If the student level of performance is worsening, however, it may be necessary for preceptors to carefully share their concerns with students and seek external help accordingly. As one preceptor cautioned, "You are not going to dive into their private life and let them tell you all about their private life, but you are saying what is causing your difficulty." Given the stressful nature of the clinical experience for nursing students (Oermann & Garvin, 2002; Timmins & Kaliszer, 2002; Yonge et al., 2002), the overall effect of financial and other stressors on students requires further exploration. An understanding of these stresses and the difficulties that nursing students face in their clinical experience may enable faculty and preceptors to more carefully plan learning experiences and provide the assistance that students need.

Clinical Learning Environment

Some preceptors suggested that the kind of learning environment to which students are assigned creates factors that can also contribute to unsafe practice. They felt that if a student is placed on a unit where a variety of learning opportunities is unavailable, they might not acquire the experiences that they need. Other preceptors also believed that students may feel scared when they are placed in a busy or completely new setting.

The preceptors suggested that the kind of clinical settings in which students are placed requires more consideration. Therefore, before assigning students, faculty members must assess the clinical sites to determine whether there is a sufficient patient population to meet the students' learning needs.

Language Barrier

Other preceptors also believed that students may engage in unsafe practice because of the language barrier, a view that has been highlighted in the literature (Yonge et al., 1997; Yonge et al., 2001). This means that such students cannot communicate effectively and are therefore likely to misinterpret instructions, which may in turn lead to unsafe practices such as making medication errors.

Several authors affirmed that the language problems that nursing students with English as a second language (ESL) face may affect their academic achievement in nursing programs (Guhde, 2003; Jalili-Grenier & Chase, 1997; Phillips & Hartley, 1990). Jalili-Grenier and Chase explored the retention of ESL students in nursing in Canada and found that these students had more difficulty with their clinical courses than did non-ESL students, which the researchers attributed to the high level of interactive communication skills that are needed in such courses. Guhde also confirmed that many ESL students have academic problems in both theory and clinical courses because of the language problem. Effective communication is an integral part of safe and competent or effective nursing practice. Therefore a student with a language barrier is likely to have a communication barrier. Nursing is highly dependent on accurate verbal communication because much of the information and many orders are passed on verbally. The student's inability to properly communicate a change in a patient's condition could delay care or cause injury.

Nursing also depends on written communication in terms of translating doctors' orders and recording patients' data. Improperly written communication or poor documentation because of a language barrier may lead to a liability lawsuit for the nurse

and the school and hospital. Communication barriers may also cause frustration or stress for students, preceptors (Yonge et al., 2002), other staff members, and patients. Phillip and Hartley (1990) divided language skills into four categories: reading, listening, speaking, and writing. Student success in clinical courses requires proficiency in each of these areas.

Preceptors' Perceptions and Feelings

Precepting undergraduate nursing students can be a challenging, demanding, and often stressful role for preceptors (Atkins & Williams, 1995; Grealish & Carroll, 1998; Yonge et al., 2002a). However, it also offers many rewards (Allen, 2002; Bashford, 2002; Yonge et al., 2002a). For example, Bashford found that preceptors feel pleasure and satisfaction in watching students improve their psychomotor and clinical judgment skills. Similarly, the preceptors in this study reported that they enjoyed precepting students and described watching the students as they progressed as a rewarding experience. The preceptors also recognized that they also grew personally in their role. They commented that through the process of teaching, guiding students, and having discussions with students, they learned from the students as well. Moreover, one preceptor suggested that precepting students improves personal critical thinking skills and encourages the preceptor to engage in self-reflection: "It's good, . . . a learning experience, . . . because it makes [the preceptor] think about what she is doing and why she is doing it in order to explain that to the student. . . . It makes you do a self-evaluation." Engaging in discussions with students and answering their questions forces preceptors to think more about their practice and create a new understanding of it. These findings concur with the positive rewards of precepting that have been identified in the literature (Hills et al.,

1999; Letizia & Jennrich, 1998; Öhrling & Hallberg, 2000), including the opportunity to improve existing skills through personal preparation for the role, mutual learning, the sharing of knowledge, and the stimulation of personal thinking and satisfaction.

In Hill et al.'s (1999) study the preceptors considered observing the student grow as the most rewarding aspect of the role. They described a sense of great satisfaction in having contributed to the students' professional growth and improvement in their own personal and professional growth as the most rewarding aspects of the preceptor role. In a qualitative study of the lived experience of 17 nurses (Öhrling & Hallberg, 2000), the preceptors reported increasing their awareness of their own process of learning, relating student experiences to their own previous learning situations, and increasing their self-reflection.

Second, the results of this study suggest that the process of precepting students can be demanding and challenging in terms of the extra time spent on preparation. Many preceptors in this study acknowledged that precepting a student with unsafe practices can be difficult, frustrating, and time consuming because of the extra time one spent on teaching and guiding them. Working with such students can also be stressful because they need constant, close supervision (Rittmann & Osburn, 1995; Robinson et al., 1999; Yonge et al., 2002a). These preceptors identified the sense of fear that they feel when they work with students who exhibit unsafe practices, because, although they want to give students an opportunity to practice in a clinical setting, they also have to think about patient safety. The preceptors recognized the competing demands of encouraging student independence and being professionally obliged to ensure safe and competent practice. Similarly, Robinson et al. (1999) reported that the preceptors in their study found it hard

to simultaneously balance the need to closely supervise students with the need to allow them clinical independence. These issues need to be explored to ascertain the effects of precepting borderline or unsafe students on the lives of preceptors. As Yonge et al. (2002b) cautioned, preceptors who feel overworked or strained with the extra responsibility of precepting students with unsafe practices risk burnout and may be less eager to accept students in the future.

With regard to evaluating students with unsafe practice, most of the preceptors in this study stated that evaluation can be difficult and time consuming: "It's time consuming because of the paper work involved"; and "I think, 'Oh! . . . A lot of paper work! . . . Lots, lots.' . . . And then you were supposed to evaluate every two weeks." These findings concur with those in previous research that students with unsafe practice are a challenge to precept and require a great deal of time and energy (Ilott, 1996; Rittman & Osburn, 1995; Shapiro et al., 2002; Yonge et al., 1997a). Ilott reported that fieldwork supervisors complained about the extra time required to supervise a marginal student, which also detracts from their clinical work. They ranked the amount of time involved in supervision, including preparation, planning, and feedback, as the second most problematic aspect of their role. The finding that evaluation involves a large amount of paperwork is also consistent with that in previous research (Calman et al., 2002; Pulsford, Boit, & Owen, 2002; Yonge et al., 1997a). Yonge et al. explained that some of the preceptors in their study felt that the evaluation part of their teaching role was difficult because of unacceptable evaluation forms, difficulty with objectivity, and time pressures. Similarly, the preceptors in Calman et al.'s (2002) study viewed completion of clinical competence assessment tools as paperwork and as a tedious formality rather than

an integral part of students' supervision and education. Pulsford et al. (2002) also concluded that preceptors want more time to complete the paperwork related to their role, less paperwork, and more 'user-friendly' clinical assessment documentation. These findings imply that nursing faculty should provide clearer or more user-friendly evaluation formats. Perhaps nursing faculty need to involve preceptors in revising the forms to give them an opportunity to have a direct say in the nature of the documents that they will be required to complete with students during their clinical placements.

These findings also support previous research that identified the large amount of time needed for undertaking preceptorship activities as a significant factor (Atkins & Williams, 1995; Coates & Gromley, 1997; Pulsford, Boit, & Owen, 2002). Coates and Gromley (1997) asked preceptors, students, and nurse managers to identify factors that enhance and hinder carrying out preceptorship activities. The majority of the respondents cited lack of time as the main barrier to working effectively as a preceptor. The participants in the current study stressed the need for protected time for preceptors and students to work together. In support, the nurse managers suggested that preceptors need to be allocated time in the same way that patient care is scheduled. Although this may seem to be a common concern among practitioners involved in clinical teaching because of the dual and often conflicting demands of supervisory and clinical roles, preceptors still need to be given protected time to be able to fulfill the role effectively.

The preceptors in this study further commented that evaluation processes can be frustrating, especially in dealing with students who are overconfident and not receptive to feedback. It is possible that some of these students may not be unaware of their incompetence (Hendrickson & Kleffner, 2002; Kruger & Dunning, 1999). Preceptors

must therefore realize that when students fail to recognize that they have performed poorly, they assume that they have performed well. As a result, incompetent students tend to grossly overestimate their skills and abilities (Hendrickson & Kleffner, 2002; Kruger & Dunning, 1999). Studies have revealed that incompetent individuals lack the metacognitive skills necessary for accurate self- assessment and therefore overestimate their performance (Hendrickson & Kleffner, 2002; Kruger & Dunning, 1999), which may lead to frustration and in turn unwillingness to be receptive to feedback. Such individuals rarely receive feedback that might assist them in developing an accurate view of reality and do not learn from feedback unless it is precise and frequent (Hendrickson & Kleffner, 2002).

Preceptors' Feelings After Failing a Student

The preceptors in this study reported a variety of feelings, including relief, anxiety, self-doubt, anger, and frustration, in the process of evaluating students with unsafe clinical practices. Previous studies have identified similar feelings (Hrobsky & Kersbergen, 2002; Ilott & Murphy, 1997). For instance, Hrobsky and Kersbergen (2002) reported that preceptors felt fear, anxiety, and self-doubt as they went through the process of coping with assessment, reporting, and resolving a scenario in which they failed students. One preceptor commented, "I felt like I killed somebody. I killed somebody's career" (p. 552). Similarly, Ilott and Murphy suggested that the process of assigning a failing grade provokes emotional responses that include anger, self-doubt, guilt and blame, and sadness among the participants. One experienced lecturer in that study acknowledged that the process of assigning a failing grade is emotionally draining and requires a great deal of support.

Most of the preceptors in this study commented that instructors are very supportive. Five had failed students, and although some of them reported feelings of guilt or self-doubt, it was encouraging to hear that others actually felt good about their decision. This finding concurs with the findings from Ilott and Murphy's (1997) study in which clinical supervisors expressed a sense of pride in fulfilling their professional obligation to make the right decision for the right reason. This is reassuring because instructor support is a factor in enhancing a preceptor's ability to work effectively with students. On the other hand, one preceptor felt otherwise and described her experience as frustrating because she viewed the instructor as not supportive or unreceptive to her concerns. This preceptor explained that, initially, when she communicated her concerns to the instructor, the instructor advised her to give the student time to improve, which she accepted. However, after two weeks there was still no improvement in the student's performance, and again the preceptor communicated with the instructor and was advised to give the student a chance to improve. The preceptor reported that when the instructor arrived on the unit, the preceptor wanted to have a joint meeting to develop an action plan; but, to her surprise, the instructor did not want to listen to her concerns and quickly left the unit. The preceptor further reported that the instructor accused her of being uncooperative, unsupportive of the student, immature and inexperienced, and therefore not appropriate to be a preceptor for the student. The instructor believed that there was a personality conflict between the preceptor and the student, and eventually, the instructor decided to remove the student from the unit.

Preceptors have raised similar concerns in previous studies (Ferguson, 1996; Lyon & Peach, 2000). Lyon and Peach explored the views of primary care providers on

precepting students. One preceptor in their study recalled a negative experience with a faculty member. The preceptor explained that he or she had once had a student who was not performing to the expected standard. The preceptor called the faculty member to validate her findings and to get assistance and some concrete guidelines on dealing with this student, whom he or she did not believe should graduate into practice. However, the preceptor was surprised and disappointed when the faculty member arrived on the unit for "a benign visit, but didn't go into the room where the student was seeing the patient" (p. 239), which the preceptor felt was not very helpful. In this difficult situation the preceptor expected the faculty member to have been more helpful and supportive, but that was not the case. Sharp (2000) cautioned that preceptors can be demoralized and feel that their professional role is being undermined when instructors fail to support them, which may result in preceptors' low morale and lack of enthusiasm, to the ultimate disadvantage of students. These findings affirm the importance of the instructor role, especially when preceptors are dealing with students who are struggling.

Congruent with the findings from previous studies (Allen, 2002; Ferguson, 1996; Lyon & Peach, 2000; Yonge et al., 2002b), most of the preceptors in this study also reported infrequent visits or contact with instructors. In fact, some preceptors reported not having seen an instructor at all or only once during the placement. For instance, one preceptor commented that with her first two students she neither saw nor heard from the instructor, even though she had left a message for the instructor. However, when instructors maintained contact or assisted preceptors with particular issues, the reports were favourable. For example, one of the preceptors spoke in detail about her recent positive experience with an instructor; she described the instructor as

excellent and supportive and explained that the instructor visited the unit frequently (at least once a week or every two weeks). During the visits the instructor would sit down and have a discussion with both the student and the preceptor.

These findings confirm that preceptors need support from instructors. They need to know how to deal with the "unsafe" student or the failing student and many other challenging teaching-learning situations that they may face. This is essential because preceptors who perceive instructors as uncommunicative or disinterested may be reluctant to continue precepting and may 'badmouth' the institution. The preceptors identified site visits and telephone calls as significant in increasing their satisfaction and maintaining the line of communication (Ferguson, 1996). They need considerable support and advice from instructors to enable them to make critical decisions about students' clinical competence. Nursing faculty and administrators need to realize the important role of preceptors in the preparation of future nurses. Therefore, supporting preceptors and students in clinical practice is important if we are to ensure that our nursing education programs produce competent graduate nurses who are able to function in an ever-changing work environment.

Grading Issues

One of the guiding questions in the interview was, "In your experience, do students sometimes pass clinical placements without having gained sufficient competence?" The majority of the preceptors in this study acknowledged that some students pass their clinical practicum without sufficient clinical experience. They gave examples of new graduates who they believed were not competent in their graduate role.

For instance, a student had graduated without giving an injection, and some final-year students did not know *how* to give an injection. As one recounted:

> I had a student who was to give an IM medication who said she knew how to do it. . . . She was going to give [it] on the gluteal muscle. She didn't mark it, and she was going straight for the midsection of the buttock area, and so I had to stop her.

This finding is consistent with the findings from Hrobsky and Kersbergen's (2002) study in which a preceptor expressed concern about a student who did know the injection sites and did not check landmarks before giving an injection. The findings from these studies suggest that students may be graduating without mastering some of the basic nursing skills.

The preceptors in this study discussed other issues: that sometimes instructors pass students even when concerns have been raised about their clinical performance and the related concern that occasionally instructors assign students' final grades without taking into account the preceptors' evaluative comments. However, although the preceptors believed that instructors consider their evaluative comments when they determine the final grade, they questioned whether students might think otherwise. Preceptors view failing a student as an act of bravery, a decision that is not taken lightly and occurs only in situations in which the student's performance is seen as very much substandard. One of the preceptors stated:

> It's very serious to fail a student, you know, [and] I will never take that lightly. . . . It would have been extremely serious to fail a student, and at the same time I wouldn't pass them if they didn't measure up.

Therefore, when instructors do not take preceptors' recommendations that students be failed into consideration, the preceptors may feel devalued. One questioned why the preceptors' decisions should be overruled, because she believed that preceptors have

legitimate authority to assign a failing grade if students are not performing to the expected standard. Similarly, a preceptor in Rittman and Osburn's (1995) study was disappointed when the clinical faculty decided that a student whom the preceptor had identified as unsafe and marginally competent should graduate. Other preceptors cited examples of preceptors who had refused to continue to precept students after the school had overruled their decisions to fail students.

The lecturer participants in Hawe's (2003) study raised similar concerns. Hawe's findings were full of examples of failing grades being overturned (p. 376). The participants in that study referred to losing confidence in their judgements and losing faith in the educational system, and one participant reported that "she did not feel encouraged to participate professionally any more" (p. 375). Unless such issues are carefully handled, preceptors may feel betrayed by the educational system and withdraw from precepting students completely. This would be highly unfortunate for all stakeholders in preceptorship programs and for the professional credibility of instructors. However, it is encouraging to note that some of the preceptors realized their important role as gatekeepers to the profession and, as such, stated that they do not take the issue of failing students lightly.

Reasons Not to Fail Weak or Unsafe Students

One of the concerns in this study was the reluctance of preceptors to assign failing grades for poor performance. However, this reluctance has been reported in a number of professions, including nursing (Duffy, 2004; Duke, 1996; Lankshear, 1990; Scanlan et al., 2001), medicine (Dudek et al., 2005), education (Hawe, 2003), and occupational therapy (Ilott & Murphy, 1997; Verma & Patterson, 1998). The preceptors in this study

identified several reasons that students pass when their performance is not up to standard, and I explored the reasons for preceptors' reluctance to fail students to understand this issue more clearly. Some attributed it to their lack of experience or confidence in their preceptor role. Clinical teachers and mentors in previous studies (Dudek et al., 2005; Duke, 1996; Scanlan; 2001) expressed similar concerns. Scanlan et al. suggested that novice clinical teachers have difficulty in evaluating students because of their lack of preparation for their evaluation role. Being uncertain about their role, especially in evaluation, preceptors, like novice clinical teachers, are more likely to pass students "because they are unsure about the legitimacy of their judgments and their ultimate decision about the student's abilities" (p. 26).

Some preceptors choose to pass students because they do not want to jeopardize the students' future, especially when they are so close to graduating and because of the significant personal cost to the student. In fact, a few preceptors suggested that they are reluctant to fail students because of the amount of money involved in receiving a university education. These findings are consistent with the findings from previous studies (Duffy, 2004; Hawe, 2003; Ilott & Murphy, 1997). The preceptors saw failing a student at this late stage as unfair because of the significant personal cost to the student (of having to withdraw from a course or ending his or her career goal) and to parents or partners. Other researchers discussed similar views (Dudek et al., 2005; Duffy, 2004; Duke, 1996; Hawe, 2003; Ilott & Murphy, 1997; Smith et al., 2001). Duke reported that sessional clinical teachers were worried about the impact of clinical failure on the student's career choice. Hawe (2003) found that lecturers believed that students should be allowed to pass if they are in their final year or semester because of the significant

personal cost to them. Ilott and Murphy explained that some students may be fulfilling a parental career goal; thus, "failure ends parental expectations but at a cost of disappointment and maybe disapproval" (p. 313).

On the other hand, in Hawe's (2003) study lecturers reported that, although management acknowledged and affirmed in documents the role of the college as gatekeeper to the teaching profession, some managers were concerned about the retention of students and the related funding of the institution. They appeared to stress the implication that failing students would worsen the funding problem and that the college could not afford to lose too many students. However, Parrott (1993) cautioned that "society demands that educators [or preceptors, in this case] and institutions of higher education be accountable for preparing safe and competent practitioners, who can in turn be held accountable for their own action" (p. 14).

Whereas the literature highlighted the fear of legal consequences (Boley & Whitney, 2003; Diekelmann & McGregory, 2003; Dudek, et al., 2005; Duffy, 2004; Smith, et al., 2001) as one of the contributing factors to the reluctance to fail a student, it was not an issue for the preceptors in this study. This may be partly because, unlike in the UK (Duffy, 2004) and in other professional programs, in nursing education the faculty retain the ultimate responsibility for evaluating and grading students' clinical performance (Ferguson & Calder, 1993).

Nursing is perceived as a caring profession; thus failing a student in clinical practice may be seen as an uncaring practice (Duffy, 2004; Duke, 1996; Scanlan et al., 2001). Some of the preceptors in this study agreed that this is so. It is interesting to note that this reluctance to fail has also been reported in academic and clinical settings in

occupational therapy, medicine, and social work, which are perceived as social, altruistic or humanist, and caring professions. It seems, therefore, that educators' commitment to and concern for students take precedence over a dispassionate consideration for the quality of their work or performance (Duffy, 2004; Duke, 1996; Hawe, 2003; Ilott & Murphy, 1997). In previous studies (Ilott, 1996; Ilott & Murphy, 1997), conflict in values between the role of occupational therapists and that of educators emerged as the most frequent reason for not failing students. Similarly, Duke revealed that, although the sessional clinical teachers in that study were skilled in identifying student problems, they were reluctant to make difficult evaluation decisions because of low self-esteem, role conflict, and their ethic of caring. The conflict of managing the nurse-teacher-career roles resulted in the sessional teachers' inability to differentiate between their students' well-being and that of the patients and the profession. It appears that the teachers' moral caring interfered in their objective evaluation of clinical performance. They were so concerned about nonmaleficence (i.e., doing no harm) that they were unable to fail students, and they worried that failure could potentially alter student career choices (Duke, 1996).

An ethic of care places caring at the center of decision making. It is concerned with relationships between people and with a nurse's character and attitude toward others (Perry & Potter, 2001). Watson (1988) suggested that caring as a moral ideal determines the stance from which one intervenes as a nurse. This perspective is crucial for ensuring that nurses practice ethical standards for good conduct, character, and motives (Perry & Potter, 2001). Noddings (1984) defined caring as a feminist framework for ethics and describes the teacher-student relationship. The author considers the teacher's highest priority as the facilitation of the students' ethical development. As such, a caring teacher

or preceptor, in this case, believes that providing for the good of the student is the highest level of ethical behaviour. Consistent with the ethics of caring (Watson, 1988) and the ethical principles of nonmaleficence and beneficence (Noddings, 1984), the preceptors in this study, like many others in previous studies (Duffy, 2005; Duke, 1996; Hawe, 2003; Ilott & Murphy, 1997), were concerned about 'doing no harm' and were unable to fail students. They were worried about the negative impact of failure on their students' career goals.

In some instances the preceptors interpreted awarding a failing grade to a student as their own personal failure or incompetence, a view highlighted in previous studies (Diekelmann & McGregory, 2003; Duffy, 2004; Duke, 1996; Hawe, 2003; Ilott & Murphy, 1997; Lankshear, 1990; Scanlan et al., 2001). Diekelmann and McGregory described an experienced faculty member who was torn between ensuring patient safety and promoting student success. The faculty member reported her experience of trying to be objective while struggling to find a reason or explanation for a student who was failing. She explained that even after many years of teaching clinical, she still felt that she was a failure when a student failed (p. 433). In Ilott and Murphy's study, a participant who had failed a student commented, "We have failed to get him through" (p. 310), a reaction that revealed the acute sense of personal failure that assessors feel when students do not achieve a successful outcome. Ilott and Murphy further asserted that "failure is an emotive term due to the destructive association between failure on a prescribed task and failure as a person" (p. 308). Educators in both academic and practice settings may be reluctant to fail a student because if they do, they would be asked, "What is wrong with your teaching?" which places the responsibility for the student failure on the lecturer.

Lecturers in Hawe's (2003) study did not want to label student failures or to have to answers questions about their own performance. Assessment in this case was perceived as an activity that reflected both personal and professionally on the performance of a lecturer. Awarding a failing grade implies that the lecturer has failed (Hawe, 2003).

It is also possible that giving negative feedback provokes feelings of guilt in the preceptors about not having spent enough time with their students, which may be flashbacks to their own student days and reveal their sensitivity to memories of negative feelings (Mahara, 1998; Rittmann & Osburn, 1995; Yonge et al., 2002).

Moreover, some of the preceptors suggested that they may be reluctant to fail students for fear that other staff members or students will label them bad people (Anders, 2001; Ilott & Murphy, 1997; Lankshear, 1990). Hawe (2003) noted that some lecturers who acted as advocates for students were pressuring colleagues to reconsider a failing grade. Ilott and Murphy found that lecturers and clinical supervisors were more concerned about the reaction of other students than that of their peers when they assigned a failing grade to students. In Lankshear's study (1990), the participants complained that giving a failing grade not only inevitably results in additional work for the assessor, but also involves having to deal with the resentment of other students and being labelled a troublemaker. Likewise, one preceptor in the current study admitted that she would not want to fail a student because of the extra workload involved (Dudek et al., 2002; Duffy, 2004; Lankshear, 1990).

Furthermore, some preceptors indicated that sometimes they pass students because of the close relationship between the student and preceptor or that preceptors feel that the student is a 'nice' person (Andres, 2001). This finding is consistent with

the findings from Hawe's (2003) study that sometimes students are passed based on their general personal traits and characteristics or the notion that they are 'good' students, which is unethical. Theis (1988) explored senior nursing students' perspective of unethical teaching behaviour. The findings reveal three major ethical principles that had been violated including justice, or unfairness, such as showing favouritism toward some students. Although preceptors are encouraged to develop good relationships with their students, it is crucial that they maintain clear professional boundaries to be able to give their students objective and effective feedback. The ability to establish and maintain professional boundaries with students is an essential component of safe and ethical practice in the teacher-student relationship. In fact, "Maintaining professional boundaries is a competency in nursing" (College & Association of Registered Nurses of Alberta [CARNA], 2005, p. 2). Therefore preceptors are expected to demonstrate an ethical approach in their teaching and evaluation of students and comply with the CNA Code of ethics for RNs (CNA, 2005).

Other preceptors in this study suggested that preceptors sometimes pass students just to "get them out of their way," thereby leaving the problems for the next person to deal with (Duffy, 2004). For instance, preceptors who do not like confrontation may find it easier to pass than to fail a student. The findings suggest that the concept of conflict resolution requires special attention in the preceptorship workshops because most nurse preceptors prefer to avoid conflict and confrontation (Johantgen, 2001; Speers, Strezywski, & Ziolkowski, 2004).

Reluctance to fail students based on poor noncognitive or affective skills has been documented in nursing (Duffy, 2004; Lankshear, 1990) and other health

professional literature (Hayes et al., 1999; Wollf-Burke, 2005). The participants in Lankshear's study identified students who should not have passed because of their attitude towards patients, but they were unable to fail them on these grounds alone. Hayes et al. (1999) reported that noncognitive behaviours accounted for 56.7% of the behaviours of concern, but only 35% of these behaviours resulted in a negative outcome for the student. Likewise, some preceptors in this study expressed difficulty in passing a student based on poor attitude or unprofessional behaviour. One preceptor commented that the current clinical evaluation tool has too few objectives in the affective domain, such as attitude, and thus it is difficult to fail a student based on poor attitude. Therefore, as long as the physical safety of the patient is not compromised, students are allowed to pass (Duffy, 2004; Lankshear, 1990). This concern may require further exploration to give learning outcomes related to professional behaviour and attitude prominence within the clinical evaluation tools.

The preceptors also reported that students have to demonstrate very poor level of performance before they are failed, a view reflected in previous studies (Duffy, 2004; Lankshear, 1990) in which the participants suggested that it was only when major and consistent problems were evident that they actually failed students. One preceptor in this study acknowledged that in some cases "failure to fail" occurs because preceptors either do not identify or do not deal with the student's problem early enough in the clinical placement. However, failure to communicate concerns about a student to the instructor early enough in the placement means that no action can be taken, and thus the instructor ultimately passes the student (Duffy, 2004). Moreover, delaying it until late in the rotation means that the student may not have enough time to improve. Therefore,

addressing the student's weaknesses early in the rotation is critical, especially for a student who lacks skills or abilities or an unsafe student. Some preceptors confessed passing weak students with the hope that the student would acquire the necessary skills in future placements or in practice. However, such a practice has consequences for patients, clients, students, and future preceptors (Duffy, 2004; Scanlan et al., 2001). For instance, one preceptor expressed anger and frustration at colleagues who had passed students who she felt were not ready for their final practicum. Chambers (1998) explained that such explanations for giving inaccurate and invalid assessment of clinical performance are morally indefensible because preceptors not only has an obligation to the student, but also has a responsibility to ensure that only practitioners who are competent are entered on to the professional register. Although it may seem appropriate to pass students who are questionable or borderline, faculty as well as preceptors must realize that in most cases repetition of the earlier clinical courses may assist students in forming a better clinical practice foundation. As well, early repetition may help to avoid the ordeal of failing when a student is close to graduating.

Congruent with the findings in previous research (Duffy, 2004; Dolan, 2003), some preceptors in this study stated that they find it difficult to fail a student when they have not had enough time to observe the student in practice. Because of the lack of time to observe all of the student's behaviours, preceptors may find it difficult to fail a student for actions that they were not able to observe directly. Certainly, for an evaluation to be valid and effective, it has to be based on objective data derived from the preceptor's personal observation of the student. An accurate and ongoing assessment is the basis for

effective and valid evaluation. Therefore, it is important that preceptors be given adequate time with the student to be able to perform a valid evaluation.

Furthermore, some preceptors perceived that other preceptors do not have concrete evidence or documentation to validate their claims that the student is unsafe and therefore may find it difficult to fail the student. Similarly, the participants in Dudek et al.'s (2005) study acknowledged that in most cases they did not keep records of students' performance. As a result, when challenged, they did not have evidence to support their decision because they could not recall specific incidents. Some preceptors in this study believed that it is not their responsibility to fail students as long as they have raised concerns about a student's clinical performance to the instructor. It is important, however, for preceptors to realize that instructors rely upon preceptors' evidence and perceptions to validate the final course grade.

Last, two preceptors agreed, as one suggested, that students are being passed because of "the fact that there is a nursing shortage, . . . so quickly they are rushed through." This view has not been previously raised in the nursing literature, but it is an issue that requires further exploration.

The tendency of preceptors in this study to pass students when a fail is warranted indicates that ongoing professional development and support are clearly required (Hawe, 2003). As well, preceptors must realize that when they accept the responsibility for precepting nursing students, they also accept some educational responsibilities, including evaluating students' clinical performance (Ferguson & Calder, 1993). It is crucial that they recognize the important role that they assume in this process, as well as the difficulties that they may face in incorporating it into their list of priorities. Although the

issue of "failure to fail" a borderline student is not a new problem, we must acknowledge and accept that some students will fail (Cowburn, et a., 2000; Duffy, 2004; Hrobsky & Kresbergen, 2002; Ilott, 1996; O'Mara, 1997) if we are to maintain high standards as professionals. It is essential that preceptors not avoid the difficult issue of failing incompetent or unsafe students (Cowburn, et al. 20002; Duffy, 2004). Valiga and Streubert (1991) point out, in order to maintain the nursing standards, only competent practitioners must be allowed to graduate from nursing programs.

It is reassuring that whereas the preceptors in this study acknowledged the challenges that they face in making the final decision either to fail or to pass a student, they also recognized and accepted their role as gatekeepers for the profession.

Strategies for Managing Unsafe Practice

The study findings suggest three categories of strategies for dealing with students who demonstrate unsafe practice: (a) preventing unsafe practice, (b) identifying unsafe practices early, and (c) dealing with unsafe practice.

Strategies for Preventing Unsafe Practice Before It Occurs

Almost all of the preceptors reported that they try as hard as possible to prevent unsafe practice from occurring by familiarizing themselves with the course expectations, orienting students to the unit, and sharing expectations with the students or setting clear expectations and goals with them (Langlois & Thach, 2000a; Moeller, 1984).

Being Familiar With the Course Expectations

Some of the preceptors familiarize themselves with the course expectations to gain an understanding of what the school expects from them and help to determine the students' level of competency. When students arrive on the units, some review

documents such as the course expectations, the evaluation form, and the inventory of the skills that the students have learned in previous clinical courses. This process assists them in determining the knowledge and skill level of their students and thereby enables them to help their students. In addition, some authors have suggested that before the student arrives, preceptors should arrange their schedules to ensure that they will be on duty as much as possible when the students arrive and during the students' experience. As well, they must also ensure that they set aside time to meet with students on a one-on-one basis, preferably on the first day (Kleffner & Hendrickson, 2001).

Sharing Expectations With Students

Several authors proposed that preceptors spend some time at the beginning of the preceptor relationship to get to know the student (Kleffner & Hendrickson, 2001; Langlois & Thach, 2000a). They recommended that when the students arrive on the unit, the preceptors conduct a through orientation to introduce the students to the unit. In agreement, some of the preceptors in this study perceived a thorough orientation as integral to an effective preceptorship experience. They reported that at the beginning of the practicum they clearly share their expectations with their students. This is important because having a clear understanding of the preceptor's expectations and goals may assist the students in adapting more readily to the new environment and avoiding significant problems (Langlois & Thach, 2000a). Many authors concurred on the importance of preceptors' clarifying their expectations at the start of the preceptorship experience (Kleffner & Hendrickson, 2001; Langlois & Thach, 2000a; Myrick & Yonge, 2005). Kleffner & Hendrickson (2001), for instance, suggested that preceptors communicate to their students their personal expectations and ask them questions to identify their level of

competence, the skills that they would like to develop or refine, and any special interests that they would like to explore during the experience. Similarly, Myrick and Yonge (2005) recommended that preceptors ask students to discuss their background, level of competence, expectations, and goals and jointly review the course's expectations for the practicum.

Kleffner and Hendrickson (2001) encouraged preceptors to explain the students' responsibilities and ask them to review their prior learning experiences and level of confidence in performing certain basic tasks. As well, they advised preceptors to review with their students the clinical evaluation form, the scheduled dates and times for the midterm examination and the final evaluation, the policies and procedures that the students should know on the unit, and the dress code or appearance expectations.

Similarly, some preceptors in this study stressed the importance of not only reviewing the students' expectations to determine their level of competence, but also discussing appropriate levels of supervision, guidance, and learning opportunities to achieve the students' goals. Being aware of students' expectations and goals can help preceptors to create more successful learning experiences for students and prevent unnecessary conflict that may arise from unrealistic goals. It is critical that preceptors understand the learners' level of preparation; the objectives of the experience; specific assignments; the knowledge, skills, and abilities related to their practice setting and the clients' needs; and the scope of responsibilities, the practice limitations, and the supervision requirements of students at the start of the experience (College of Nurses of Ontario [CNO], 2005; Myrick & Yonge, 2005). However, it is important that preceptors realize that not every student will enter the preceptorship experience with the same

prerequisite knowledge and skills (Gaberson & Oermann, 1999; Myrick & Yonge, 2005). One student may be very competent and confident in performing tasks, whereas another at the same level may not. This will depend on various factors such as their individual capabilities, the quality of previous learning and clinical experience, and the students' level of self-confidence (Gaberson & Oermann, 1999; Myrick & Yonge, 2005). In fact, one preceptor emphasized the need for faculty members to ensure that the clinical setting to which they assign students offers experiences that will provide the learning opportunities necessary for the students to meet their objectives. This finding concurs with those in the literature that the setting selected must facilitate students' achievement of the course objectives (DeYoung, 2003; Gaberson & Oermann, 1999; Myrick & Yonge, 2005; Reilly & Oermann, 1999). Gaberson and Oermann suggested that the clinical setting must be selected based on the ability to provide sufficient opportunities to allow students to achieve their learning objectives, the availability of role models for the students, the physical facilities, staff relationships with the faculty and students, and opportunities for interdisciplinary activities. DeYoung (2003) concurred that to ensure a positive learning experience for students, the clinical setting must ensure a learning experience that will enable students to accomplish their learning objectives.

Preceptors are also encouraged to review with their students the type of evaluation (formative or summative), the standards by which their performance will be judged, and the sources of data that will be used to determine the final grade. Manley (1997) asserted that students learn best if they are full partners in the learning experience and participate fully in the design, implementation, and evaluation of the experience. Therefore preceptors and students should collaboratively contribute to the design of the learning

experience. The preceptors' role is to help their students identify how they learn best and then, by using their own judgement and expertise, to decide on how they and the students can collaboratively implement a safe approach (Manley, 1997). The preceptor must facilitate goal setting, with expectations falling within the students' level of experience. By facilitating, preceptors allow students the opportunity to discover what they need to achieve and what they need to know in their clinical practice (Myrick & Yonge, 2005). A thorough orientation of students sets the practicum off to a good start by familiarizing them with the unit and the preceptors' expectations in a well-organized manner.

Identifying Unsafe Practices Early

The next step in managing a student with unsafe practice is to identify the unsafe practices. The majority of the preceptors in this study reported that they identified hallmarks of poor performance or unsafe practice very early in the rotation, which is consistent with the findings from previous studies (Duffy, 2004; Hrobsky & Kersbergen, 2002; Ritmann & Osburn, 1995). The preceptors accomplished this by gathering data through direct observation and close monitoring of the student, acquiring feedback from colleagues, and in some cases gathering additional information about the student from instructors. Once the preceptors recognized unsafe practices, they began to monitor them closely to ensure that they did not compromise patient safety. As one preceptor described it, "I basically take this individual under my wing, and I basically watch them like a hawk because I don't want accidents to happen."

The preceptors also checked with colleagues who had worked with the student to ascertain what they thought of the student's clinical performance or behaviour. Similarly, many mentors in Duffy's (2004) study stressed the importance of accumulating input

from colleagues to acquire a second opinion on a student's performance. Some preceptors had to contact the instructors to acquire additional information about the student to verify the level of competence and determine whether this was just a single incident or a pattern of behaviour. Although the preceptors acknowledged the issues related to confidentiality of information, they still felt that this information is important in selecting appropriate interventions for dealing with such students. Thus, preceptors are encouraged to gather data whenever possible from all sources to be able to make a decision on an appropriate plan of intervention for students. The question is, How much information should preceptors receive from instructors on students?

The issue of whether faculty should share information on a student's previous performance with the next preceptor is a dilemma that the literature has highlighted (Duffy, 2004; Gaberson & Oermann, 1999; Kleffner & Hendrickson, 2001; Verma & Patterson, 1998). For example, most of the lecturers in Duffy's study reported that it was a policy not to inform the next instructor about a student's poor performance in a previous placement to prevent bias. Similarly, faculty members at the university involved in this study are bound by the Freedom of Information and Protection of Privacy (FOIPP) Act (1999), which prohibits the disclosure of student information from one instructor to another or one preceptor to another. On the other hand, several participants believed that being aware of a student's problems allows the next preceptor and student to work on the problems immediately, thereby offering the student a better chance of success. Similarly, Verma and Patterson argued, "While the potential legal effect of forewarning an evaluator about a student's perceived weakness is unknown, it raises the specter of

unfairness and bias" (p. 164). As Duffy suggested, this is a policy issue that requires further exploration and clarification by the educational institution.

Faculty members have a legal and ethical duty to maintain confidentiality. Violating this fundamental student right may have serious ramifications for both the faculty and the student (Cherry & Jacob, 2002). Therefore, disclosure of a student's previous performance to the next preceptor may be a violation of confidentiality or invasion of the student's privacy. Apart from the FOIPP Act (1999), nursing faculty are also guided by the code of ethics not to disclose information about students that has been gathered in the course of professional services, unless disclosure serves a compelling professional purpose, such as patient safety or is required by law (CNA, 2002).

One suggestion is that individual students should identify their weaknesses and communicate their problems to the preceptor rather than the faculty member's disclosing this information to the preceptors. Students may be reluctant to talk about problems that they experienced on previous placements for fear of failing or being labelled before the practicum begins. However, the advantage of disclosure is the decreased time required to identify problems and the increased time available to help the student to improve his or her performance.

Some preceptors in this study indicated that once they confirm a pattern of behaviour, it is important for them to document their findings. They have encouraged their colleagues to document the details of specific incidents; proper documentation is an essential step in the process of addressing unsafe practice situations because it allows the preceptor to give accurate and specific feedback to the student. Several authors emphasized the importance of collecting and documenting evidence especially in dealing

with a student who displays unsafe practice (Caldwell & Tenofsky, 1996; Chasens, DePew, Goudreau, & Pierce, 2000; Parrott, 1993; Smith et al., 2001; Verma & Patterson, 1998). Caldwell and Tenofsky (1996) advised faculty members, or preceptors in this case, who evaluate students who exhibit unsafe clinical performance "to maintain scrupulous anecdotal records, keeping in mind that these documents can be made available to students as needed" (p. 24). Similarly, Smith et al. asserted that a clear, well-evidenced report not only supports the preceptor's decision-making process, but also allows the student some protection against an irresponsible decision to fail. Documentation must be factual and nonjudgmental and include the type of patient to whom the student was assigned, the learning experiences, and the student's strengths and weaknesses (Smith et al., 2001). Careful documentation and clear communication with the student who continues to be clinically unsafe may prevent the faculty's or preceptor's bias or unfair evaluation practices (Chasens, et al., 2000).

Strategies for Dealing With Unsafe Practice

Under this category the preceptors recommended the following strategies for dealing with unsafe practice: (a) Communicate the problem to the student; (b) jointly develop a plan of action; (c) communicate the problem to the instructor; (d) interrupt the student and explain the correct approach; (e) demonstrate new skills and follow it up with a repeat demonstration; (f) constantly observe and allow gradual independence; (g) encourage students to practice skills; (h) question and give students reading assignments; (i) create a good learning environment; (j) establish a good rapport with students; (k) be patient; (l) give timely, honest, and constructive feedback in private; (m) acquire input from colleagues; and (n) seek external resources.

Communicate the problem to the learner. Many authors concurred that once unsafe behaviour has been identified, it is crucial to communicate with the student as soon as possible to discuss the issue and ensure that the student knows the reason for the meeting (Duffy, 2004; Kleffner & Hendrickson, 2001; Langlois & Thach, 2000b; Myrick & Yonge, 2005). Duffy (2004) suggested that early exploration and intervention with the student is crucial. Myrick and Yonge (2005) recommended that the preceptor communicate directly with the student and establish his or her perspective on the behaviour or poor performance. Similarly, most preceptors in this study reported that once they recognized unsafe practice, they communicated their concerns to the student to determine whether the student was aware of the problem and to identify the source of or factors that contributed to the unsafe behaviours. Preceptors are encouraged to set aside a specific time and place for a private meeting and to inform the student before the meeting about its purpose (Kleffner & Hendrickson, 2001; Teeter, 2005). It is critical for the student to understand that this is not a routine "How's it going?" meeting (Kleffner & Hendrickson, 2001, p. 84). Kleffner and Hendrickson encouraged preceptors to communicate in a calm and nonjudgmental manner and to give students an opportunity for self-assessment. Similarly, Teeter and Myrick and Yonge suggested that preceptors clarify the situation with the student and explore the student's perception of the situation. Teeter further advised that preceptors admit gently, objectively, and honestly their evaluation of the student's performance and patiently assist the student in seeing the reality of the issue. It is also important that preceptors discuss the possible consequences for patients, the staff, other students, the overall experience, and, most important, for the student involved.

In agreement with the above authors, the preceptors in this study recommended that students perform a self-assessment to establish their perspectives on the situation. They saw this process as important because some students may not be aware of their incompetence and thus may require more specific feedback. Only through self-assessment can students identify areas in which they are deficient and need to improve. It is important to ensure that students fully understand the problem and to inform them about the potential implications of their behaviour or poor performance. Therefore, it is crucial for preceptors to provide a detailed description of the incidents to ensure that the student knows exactly which areas need to be improved. The next step is to develop a learning contract with the student.

Develop a plan of action. Most of the preceptors reported that once they identified unsafe practices, they tried to address the problem as quickly as possible. This is very important given the fact that students are on the unit for only a short time. However, the intervention depends on the nature and severity of the problem. For instance, if it is minor and straightforward and will have limited impact on the patient, preceptors may try to resolve the issue with the student only and without any external assistance. Similarly, Langlois and Thach (2000b) suggested that in cases of minor problems the preceptor give specific and constructive feedback on the issue and then observe carefully to determine whether that feedback is being acted upon. They believed that many learners are able to act upon good feedback and make dramatic improvement. However, for problems that cannot be resolved with informal feedback, external help should be sought (Kleffner & Hendrickson, 2001; Langlois & Thach, 2000b; Myrick & Yonge, 2005). Langlois and Thach stressed that it is important for preceptors to recognize

that if there is no improvement, the problem may be larger than they might have first thought and that help may be required. As one preceptor stated, "I thought that perhaps with some soft correction where we would stand and sort of go through things, perhaps that might clue her in, but as it progressed along, yeah, I did call her instructor." A preceptor in Duffy's (2004) study expressed a similar viewpoint. Some preceptors in this study also suggested that the approach would also partly depend on how receptive students are to constructive feedback.

Many authors recommended developing a joint learning contract or plan (Kleffner & Hendrickson, 2001; Moeller, 1984; Myrick & Yonge, 2005; Shapiro et al., 2002; Teeter, 2005) to deal with borderline students. Teeter suggested that preceptors should also develop and sign a written "contract with the student for success" (p. 92). A learning contract is a written form of an "agreement between teacher and student that clarifies expectations of each participant in the teaching-learning process" (Gaberson & Oerman, 1999, p. 213). Myrick & Yonge explained that it is important that the faculty member who is responsible for the student be informed and included in the development of the learning contract. In support of this view, some preceptors in this study also suggested jointly setting up and documenting a detailed action plan or contract to provide the student with learning opportunities to foster improvement. The contract must be objective, positive, and encouraging and focus on behaviour for success rather than failure. It should include the student's suggestions for the resources needed to improve (Teeter, 2005). In addition, the contract must include statements that "success is found in a pattern, not one incident" (Teeter, 2005, p. 92) and that all clinical objectives must be met, including set times for regular evaluation and a timeframe for success. The contract

should identify areas for development and actions needed to achieve learning outcomes and detail how this will be achieved. It should also contain criteria for success to determine how outcomes have been achieved (e.g. benchmarks, performance criteria), a date for achievement, and any lack of personal insight. For documentation purposes and to make expectations clear, preceptors are advised to provide the student with a typed copy of this plan (Kleffner & Hendrickson, 2001; Myrick & Yonge, 2005; Teeter, 2005).

Communicate the problem to the instructor. Most preceptors suggested that they would inform the instructor only if the problem happened for the second time, but in the event that it was a major problem, they would immediately inform the instructor. Some preceptors also suggested that they would give students time to improve, but if there was no change in the behaviour, then they would consult the instructor. However, several authors encouraged preceptors to contact the instructor for advice, guidance, and support even for what appears to be a relatively minor concern (Duffy, 2004; Langlois & Thaeh, 2000a; Moeller, 1984; Myrick & Yonge, 2005; Valiga & Streubert, 1998). Valiga and Streubert identified referring to the faculty early as excellent action in dealing with a weak student. Myrick and Yonge recommended involving the faculty member responsible for the student in the discussion as soon as possible, as well as in the development of the learning contract. Langlois and Thach (2000a) also cautioned preceptors to contact the school as early as possible for advice, guidance, and moral support.

Whereas the preceptor acts as the student's major support in the practice setting, the faculty member provides key educational support for both. As the custodian of the teaching-learning process, the faculty members must be informed of problems as soon as

possible so that they or she can provide both the preceptor and the student with the support and guidance that they may need. Preceptors need concrete guidelines and assistance in dealing with a student with unsafe practice (Myrick & Yonge, 2005). The faculty member assumes the ultimate responsibility for the final evaluation and grading of the student's clinical performance and therefore must be informed about a student's unsafe practice (Myrick & Yonge, 2005). Society demands that nursing faculty and programs be accountable for preparing safe and competent practitioners who will in turn be held accountable for their own learning (Chambers, 1998). Thus, as custodian of the teaching-learning process, the faculty to some extent must ensure that students possess the required knowledge, skill, and competencies to graduate from the nursing program (CNA, 2002).

Interrupt and explain the correct approach if a major mistake occurs.

Preceptors are responsible for determining the level of competence and must act accordingly. Otherwise liability for unsafe practice could fall on the preceptor. If a student cannot demonstrate the ability to deliver safe care at the expected level, the preceptor has a responsibility to intervene to avoid compromising the safety of patients. Although preceptors are accountable in working with nursing students, they are not responsible for students' actions as long as they have fulfilled their responsibilities, such as providing appropriate supervision, and if they did not expect that an error might occur. Students must be made aware that although their role within the preceptorship experience is primarily as learners, they are expected to be both responsible and accountable for their own professional actions and decisions based on their level of experience (Arshall-Henty & Vernon, 2003; CNO, 2005; Gaberson & Oermann, 1999; Myrick & Yonge, 2005;

Phillips, 2002). It was encouraging that the preceptors in this study realized their accountability to patients and the profession. Most affirmed that if they recognized a major incident of unsafe practice that might jeopardize patients' or others' safety, they would immediately stop the student and take over whatever that student was doing. Kleffner and Hendrickson (2001) asserted that correcting mistakes is a very important element of teaching because if students are allowed to proceed with a mistake that is not corrected, the possibility of their developing the wrong thought patterns is very great. Therefore, just as it is important to reinforce correct behaviour, so is it important to correct students' mistakes (Kleffner & Hendrickson, 2001).

Thereafter, the preceptors reported, they would explain to students the proper way of doing things and give them enough time to improve. In fact, in most cases students say that they learn best when they are permitted to observe a procedure before being asked to perform it (Infante, 1985). Nylund and Lindholm (1999) found that students wanted their preceptor to demonstrate the skill to provide them with an opportunity to observe. Then, depending on their performance, they can be allowed to practice the skill under the preceptor's supervision. Hendrickson and Kleffner (2002) also suggested that preceptors must take a more proactive coaching role by guiding students in patient care activities by using demonstrations, cues, prompting questions, and constructive feedback. It was reassuring that most of the preceptors in this study indicated that they initially demonstrate new skills to students and then let them repeat the demonstration before allowing them to perform it independently. Similarly, some preceptors explained that when students tell them that they can perform a procedure, they allow them to carry it out

while still closely observing them to ensure that they are doing it properly, and then give them feedback accordingly.

Observe constantly and allow gradual clinical independence. Brooke (1994) suggested that the major responsibility of the faculty or preceptor is the correct and early detection of students who are clinically unsafe. Once unsafe practice is discovered, the preceptor has a duty to supervise the student more closely. The level of supervision will depend on the preceptor's capacity to weigh his or her responsibility to provide safe and competent care against the responsibility to provide students with sufficient practical experience to meet the course objectives. Similarly, the preceptors in this study explained that once they realize that a student seems to be unsafe, they closely monitor what the student is doing and validate the level of competency until they have gained enough confidence in the student's clinical ability. As the student develops clinical competence, many preceptors allow gradual clinical independence. Once the preceptor assesses the student and is confident in his or her level of competence, the student is given increased responsibility. Preceptors must realize that close observation of students who may be already stressed out and probably have little confidence in their ability to meet the clinical objectives may worsen the student's nervousness and increase the chances of making mistakes (Haskvitz & Koop, 2004). Some preceptors also emphasized the need to encourage students to continue practicing the skills once they have correctly carried out the procedure. It is important for them to master the skills because some students, once they have successfully performed a task, do not want to perform it again.

Question and give reading assignments. A few preceptors described how they challenged students through questioning and reading assignments, and many authors

concurred that questioning is fundamental to learning. According to Lesky and Borkan (as cited in Kleffner & Hendrickson, 2001), questions offer the learner an opportunity to practice problem solving and simultaneously provide the teacher with an opportunity to observe and listen. Hagler and MacFarlane (1991) agreed and affirmed that "questions lead students through a problem-solving process by helping them merge their existing knowledge with their current experience" (p. 8). Questions, if used skilfully, can help students to direct their thinking processes, provoke interest, stimulate and challenge them, promote discussion, and evaluate their learning (Myrick & Yonge, 2005). A preceptor in this study reported that she tries to create learning opportunities for students by letting them work with the multidisciplinary team members on the unit:

> I have sometimes gotten the clinical nurse specialists involved. If it is something respiratory, we have respiratory therapists that work with us. I will get them to spend time with them as well . . . [in] the operating room to see one of our patients, or I can get you in one of the doctors' clinics.

This finding corresponds with the documentation in the literature that preceptors should assist students in consulting other clinical expertise and utilizing alternative learning resources (libraries, audiovisual aids) to supplement learning (Manley, 1997; Myrick & Yonge, 2005). Although the preceptor is seen as the primary resource person for the student, other staff members on the unit also have expertise to contribute. Therefore, it is essential that preceptors help students to identify available resources or people on the unit from whom students can learn. For instance, arranging for students to attend rounds and/or case conferences that relate to their learning experiences is often useful (Manley, 1997; Myrick & Yonge).

Create a good learning environment. Preceptors play a crucial role in influencing the nature of the clinical learning environment (Myrick, 2002). In addition to the

preceptor, the staff with whom students interact on a daily basis also play a crucial role in creating a safe environment (Dunns & Hansford, 1997; Myrick & Yonge, 2001, 2002; Nolan, 1998). The attitudes and behaviours of nurses and their relationship with preceptors also influence how the staff relate to the students (Jackson & Mannix, 2001; Myrick & Yonge, 2001). Jackson and Mannix revealed that students highly value positive relationships with clinical staff, that they view clinicians as central to the perceived success or failure of their learning in clinical placements, and that they consider the attitudes and behaviours of clinical nurses employed in the clinical settings as crucial variables. Preceptors' relationships with colleagues also influence how the staff will handle students (Myrick & Yonge, 2001). Similarly, the preceptors in this study acknowledged the importance of creating a good learning environment for their students and maintaining a good relationship with their colleagues because it influences how the staff respond to the students: If the relationship is good, the other staff members are likely to be receptive to the students. As well, the preceptors stressed the need for rapport with their students to ensure that the students feel comfortable in approaching them.

The preceptors acknowledged that working with students with unsafe practice can be stressful, especially when students continually follow them and ask questions, they were still willing to be patient and supportive with such students. In fact, patience and understanding are two key characteristics required to work with students; more specifically, with unsafe or borderline students. It is necessary for preceptors to be empathetic, to remember what it was like to be a student (Hendrickson & Kleffner, 2002; Teeter, 2005). Most authors also concurred that the environment that most effectively facilitates learning is one that reflects support; is free from threat; promotes openness,

inquiry, and trust; and avoids competitive performance judgments (Manley, 1997; Myrick, 2002; Vella, 2002). If the preceptor creates a supportive, nonthreatening environment that is open to inquiry and free from critical judgements of performance, learning will be facilitated (Manley, 1997). Manley further explained that preceptors facilitate learning when they demonstrate "accurate empathy" (p. 22), warmth, respect for the learner, and consistency in their approach to the preceptor-student relationship. Accurate empathy refers to "the ability to walk in the student's shoes, to reach into one's own memories and recall what it was like to be a student trying to learn a new skill" (p. 22). Empathic preceptors recall what it is like to learn complex skills for the first time. They actively listen and respond as students share feelings and concerns. They are warm, open, caring, supportive, and approachable when they work with students. Students need to feel comfortable in asking questions, without fear of reprisal, and they need to know that the preceptor will be there if needed. Respect and empathy for the learner are integral interpersonal skills of effective preceptors. They demonstrate respect through ensuring equality, mutuality, and shared thinking. Respect entails the preceptor's acknowledging and respecting students as adults (Manley, 1997). Preceptors are therefore encouraged to empathize with students by sharing their experiences as former students, including stories about errors that they made and how they managed to improve their performance. They need to let students know that they will try to work through the problem together and that they will work with the instructor to provide support for learning to take place (Hendrickson & Kleffener, 2002). One preceptor also stressed the importance of establishing good rapport with the instructor. This finding is consistent with the findings from previous studies (Hsieh & Knowles, 1990; Myrick, 1998), which revealed that the

relationship between the preceptor and faculty is critical in the development, implementation, and sustainability of the preceptorship experience.

Give timely, specific, honest, ongoing, and constructive feedback in private. Feedback is a key component of the evaluation process and a fundamental aspect of the preceptor-student relationship. Feedback is the mechanism by which the effective preceptor promotes positive behaviour and skills and works to modify those areas where improvement is needed (Langlois & Thach, 2001; Smith et al., 2001). Feedback provides students with the information that they need to overcome weaknesses, improve overall performance, and gain confidence in their clinical competencies (Smith et al., 2001). Learners highly value feedback (Bergman & Gitskill, 1990; Irby, as cited in Langlois & Thach, 2001; Myrick & Yonge, 2005). Myrick and Yonge asserted, "Students are used to feedback and interested in receiving feedback regarding their performance" (p.27). Bergman and Gitskill (1990) explored facultys' and students' perceptions of effective clinical teachers, and both stressed the importance of fairness in the clinical evaluation and feedback on student progress. However, to be effective, feedback must be accurate, timely, and ongoing.

Several other authors (Hendrickson & Kleffner, 2002; Langlois & Thach, 2000a; Smith et al., 2001; Teeter, 2005) suggested that preceptors give immediate corrective feedback during and after performance or when errors occur. Langlois and Thach (2002) cautioned that many potentially difficult situations in clinical teaching can be prevented by using educational techniques such as setting expectations, giving timely and constructive feedback, and providing thoughtful, ongoing evaluation. Constructive feedback identifies the weaknesses and provides specific suggestions for improvement

(Kleffner & Hendrickson, 2001). Smith et al. (2001) contended that preceptors should provide immediate and frequent feedback on clinical performance to each student. Similarly, the majority of the preceptors in this study stressed the importance of giving timely, specific, honest, ongoing, and constructive feedback. Some also pointed out the need for honest and constructive feedback to both students and instructors.

It is surprising that only one preceptor emphasized the importance of giving students immediate feedback. One reported that weekly feedback had worked well for her and her student. However, it is crucial that preceptors realize that feedback is more effective if it is very specific to the behaviour observed and given immediately after the event. Similarly, Teeter (2005) affirmed that mistakes should be corrected as soon as possible after the incident. Although this may not always be possible, every effort should be made to discuss the performance with the student at the first opportunity while it is still fresh in both the student's and the preceptor's mind (Kleffner & Hendrickson, 2001).

Most preceptors in this study emphasized the need for providing feedback in private. This finding concurs with those in the literature (Kleffner & Hendrickson, 2001; Mackin & Studva, 1997; Myrick & Yonge, 2005; Teeter, 2005; Valiga & Streubert, 1991). Teeter asserted that feedback should always be offered in a professional way without making students feel that they are failures. Valiga and Streubert explained that feedback on unsuccessful clinical performance should always be given in private, not in front of patients. Likewise, Mackin and Studva (1997) stressed that feedback should be given in a respectful and confidential manner. Offering feedback in private demonstrates a caring and respectful concern for the students (Mackin & Studva, 1997).

The preceptor must realize that failure to give appropriate and accurate feedback perpetuates poor performance among students (Andres, 2001). Cleland et al. (2005) concurred that failing to provide constructive feedback on poor performance hinders students in reflecting on and taking steps to address their learning needs. As part of their professional accountability, preceptors are expected to provide timely and accurate feedback to students on their practice (CNA, 2002). Therefore, preceptors are encouraged to give timely, detailed feedback on poor performance because the students may not see it as their responsibility to seek help, and if they are not given feedback, they may assume that their performance is acceptable. Detailed, specific feedback is important in managing students with unsafe practices because it identifies the preceptor's areas of concern for the students and assists them in implementing specific recommendations for change. Preceptors are also reminded of the importance of documenting the feedback that they provide, along with suggestions and recommendations for improvement where applicable, and a specified timeframe for behavioural change (Smith et al., 2001).

Importance of self-evaluation. Schön (as cited in Kleffner & Hendricson, 2001) suggested that experts "continuously review their own performance and determine whether or not they could have changed anything to make their performance more efficient or effective" (p. 32). Kleffner and Hendrickson (2001) concurred that professionals who develop the habit of continually assessing their own performance continue to refine their skills and improve their performance. Therefore, preceptors are also encouraged to help students to develop a personal feedback mechanism by frequently asking them to evaluate their own performance and determine whether or not anything could have been performed at a higher level or in a more efficient manner.

The preceptors in this study also stressed the need for self-evaluation. One preceptor recommended that colleagues reflect on their own practice to ensure that they are practicing within the acceptable standard of practice before concluding a student is unsafe. This is crucial because some preceptors may believe that their own way of performing procedures is the only right way. As one preceptor explained, "You need to look at your own practice and see whether or not you are imposing some sort of philosophy [of doing things] that you have on the student and take it that they are unsafe." In fact, nursing registration boards in many countries have adopted reflection as a prerequisite for registration (Burton, 2000; Brown et al., 2001; Teekman, 2000). For example, the Nursing and Midwifery Council (NMC), the College of Nurses of Ontario, Canada (CNO), CARNA have adopted reflection as a mandatory and essential component of nursing practice and registration and expect all future nurses to engage in some form of reflective practice (Brown et al., 2001; CARNA, 2002). Reflective practice is one of the requirements of the continuing competence program for all CARNA members. All RNs in the province are expected to document how they have used the reflective practice approach in their practice.

Seek external help. Some preceptors suggested that if the above actions have failed to rectify the situation and the preceptor is relatively new to the role, then he or she must seek guidance from a more experienced preceptor or colleague. As indicated earlier, preceptors are advised to solicit help from colleagues or instructors as early as possible when they realize that they cannot adequately resolve a situation or when they need more information on the student to confirm a pattern of behaviour at the earliest opportunity. Similarly, Öhrling and Hallberg (2001) found that preceptors conferred with other nurses

who had worked with the student for confirmation on the student's progress. If the student continues with unsafe behaviour, then preceptors must seek external advice early on to discuss their concerns with the instructor, other preceptors, or the unit managers. However, as pointed out earlier, the practice of indiscriminate sharing information on the student's previous performance violates the FOIPP Act (1999) and the ethical principle of confidentiality.

Use remedial interventions and make a decision to fail. The preceptors recommended several strategies in cases where the above strategies did not resolve the problem, most of which have been documented in the literature. These include changing the environment or preceptor (Shapiro et al., 2002); reducing the student's patient assignment (Rittmann & Osburn, 1995; Shapiro et al., 2002); reviewing areas of practice with the instructor; offering additional/repeat practicums (Shapiro et al., 2002); and counselling the student to discontinue the program (Myrick & Yonge, 2005; O'Mara, 1997; Shapiro et al., 2002; Teeter, 2005). Some preceptors suggested that placing the student on a different unit or with a different preceptor will ensure fairness in the evaluation process; furthermore, reducing the student's patient assignment by arranging clinical experiences in which he or she can succeed by including smaller, less complex assignments than those that other nursing students were able to accomplish might resolve the problem (Rittman & Osburn, 1995; Shapiro et al., 2002). Others recommended that once unsafe practice is recognized, the student and instructor should revise the specific areas in which the student needs to improve to practice safely. Thereafter, the student should be tested before being allowed to return to the unit. Other preceptors believed that giving students a chance to repeat the practicum will lead to success. Finally, the majority

of the preceptors recommended that if the problem of unsafe practice cannot be resolved, for the sake of patient safety, the student should be failed or counselled to discontinue the program, a view that several authors supported (Moeller, 1984; Shapiro et al., 2002; O'Mara, 1997; Myrick & Yonge, 2005; Teeter, 2005; Valiga & Streubert, 1991). Moeller stressed that "it is better that such a student suffer the temporary inconvenience of repeating the practicum than enter the profession with substandard skills" (p. 205). Similarly, Valiga and Streubert (1991) pointed out that, to maintain nursing standards, preceptors and faculty must ensure that only accountable, responsible, and competent practitioners are allowed to graduate from nursing programs.

Ethics and Accountability Issues

In this section the ethical and accountability issues that emerged from this study are discussed. These issues were related primarily to the presence of students in a practice setting; the need for faculty-student relationships to be based on the ethical principles of justice, veracity, and respect for individuals; student's privacy rights; and teaching competences (Gaberson & Oermann, 1999).

Ethics

Ethics refers to standards of conduct or right behaviour based on moral judgement. Ethics is concerned with the norms of right and wrong, of what is thought good or bad, and of "ought" and "ought not" in respect to values and behaviours between persons. Professional values and responsibilities are delineated for nurses in documents such as the Code of Ethics for RNs (CNA, 2002), nursing standards and competences provided by individual provinces, and institutional polices and procedures that guide nurses in professional behaviour. The CNA Code of Ethics is organized around eight

primary values that are central to ethical nursing practice. These are (a) safe, competent, and ethical care; (b) health and well-being; (c) choice; (d) dignity; (e) confidentiality; (f) justice; (g) accountability; and (h) quality practice environments (CNA, 2002). In addition, each provincial nursing association in Canada also has shared values such as those identified in position statements and practice standards. The Code of Ethics for RNs provides a framework within which nurses can make ethical decisions and fulfill their responsibilities to the public, to other members of the health team, and to the profession. Although the Code of Ethics guides nurses in their decisions, it does not provide a means for establishing priorities when there are conflicts between ethics or values. Ultimately, the nurse must make the choice for him- or herself (CNA, 2002; CNO, 2005).

Accountability

Accountability entails responsibility; anyone who is responsible is thereby accountable. Cherry and Jacob (2002) defined *accountability* as "an ethical duty stating that one should be answerable legally, morally, ethically, or socially for one's activities" (p. 198). Accountability in nursing is undeniably multifaceted. Registered nurses are accountable to themselves, their patients/clients, their colleagues, the profession, the employer, and society. They have a responsibility to clients whilst being contractually accountable to the organization or health care agency that employs them, and professionally accountable to the professional body and to society as a whole (Arshall-Henty & Vernon, 2003). Nurses are accountable for the quality of care that they provide to patients and for taking action when client safety is at risk (CNA, 2005; CNO, 2005). In compliance with these guidelines, all of the preceptors in this study agreed that if a student is unable to demonstrate the ability to provide safe care at the expected level, it is

their responsibility as preceptors to intervene to avoid compromising the safety of patients. Nurses are also expected to be accountable to the public and responsible for ensuring that their practice and conduct meet legislative requirements and the standards of nursing practice (CNO, 2005). The contract between the profession and society is made explicit through such mechanisms as "(a) the Code of Ethics for nurses, (b) the Standards of Nursing Practice, (c) educational requirements for practice, (d) certification, and (d), mechanisms for evaluating the effectiveness of the nurse's performance of nursing responsibility" (American Nurses Association, 1997, pp. 3-4). Last, nurses are accountable to themselves and to other health care professionals.

Accountabilities for Preceptors

Figure 3 illustrates the multifaceted accountabilities of preceptors (Arshall-Henty & Vernon, 2003; Harding & Greig, 1994; Valiga & Streubert, 1991). In the preceptor role, while nurses are contractually accountable to the university, they also have professional and moral responsibility for the students whom they undertake to teach and evaluate, and to society as a whole. As a consequence of their role, preceptors enter into a formally recognized contractual relationship with the university or college that involves clinical evaluation of students. This responsibility forms part of the preceptor's role or job description. Second, each preceptor enters into a contract with the students to provide the learning experiences that are required (Harding & Greig, 1994; Valiga & Streubert, 1991) and to which the student is entitled.

Although preceptors are also accountable for supervising and evaluating the student, they are not accountable for their students' actions as long as they have fulfilled their responsibilities as outlined in the preceptor manual, such as (a) selecting appropriate

activities based on objectives and determining that the students have the prerequisite knowledge, skills, and attitude necessary to complete their assignments (CNO, 2005; Gaberson & Oermann, 1999); and (b) providing appropriate guidance and supervision (Cherry & Jacob, 2002; CNO, 2005; Gaberson & Oermann, 1999).

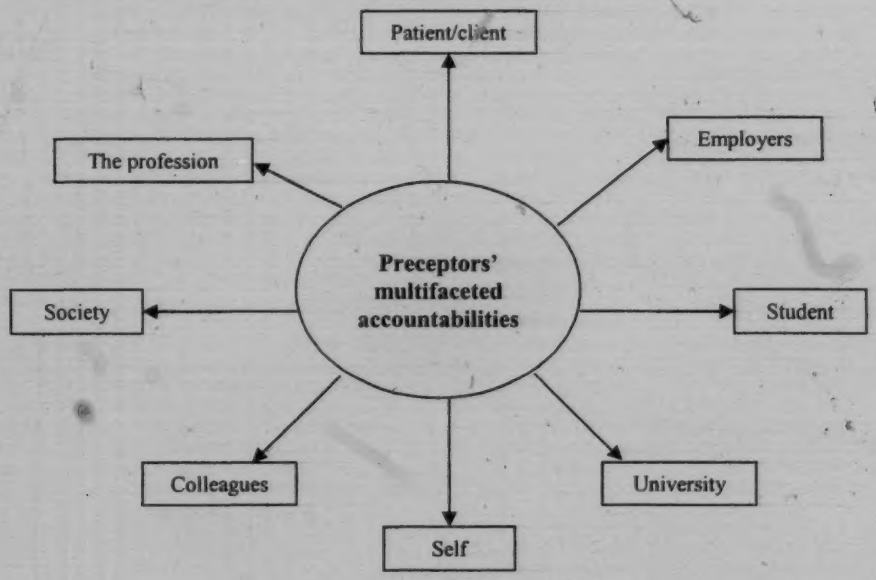

Figure 3. Preceptors and their multifaceted accountabilities in the preceptorship experience.

While working with students, nurses are expected to place the safety and well-being of the client above all other objectives, including fulfilling their educational obligations (CNO, 2005). The preceptors in this study readily acknowledged their accountability for ensuring safe patient care while facilitating student learning. As one preceptor explained, "You want safe care for your patients, and, ultimately, patient care is my responsibility." Another asserted, "I am very cognizant of [the fact] that these [students] are people that have not had experience as nurses; they are students still, and I feel that I have ultimate responsibility for patient safety."

Preceptors must realize that although students are in the practice setting primarily as learners, they are still expected to be responsible and accountable for their own actions and decisions based on their level of experience (Arshall-Henty & Vernon, 2003; CARNA, 2002; CNA, 2005; CNO, 2005, Myrick & Yonge, 2005; Phillips, 2002). For this reason, students, like RNs, are expected to provide safe and competent care for their patients. Students have a responsibility to participate in their own self-assessment and communicate their learning and supervisory needs, as well as errors, in a timely manner to the preceptor (Brooke, 1994; CNO, 2005; Gaberson & Oermann, 1999) and to become familiar with and adhere to the agency's policies and procedures (CNO, 2005). Therefore, students have a duty to seek help when they are unsure of their capabilities in conducting nursing activities and to provide safe and competent care to patients.

Ethics and Accountability Issues Specific to this Study

Beauchamp and Childress (2001) offered several frameworks for resolving ethical issues and dilemmas. The most commonly used is the four principles framework, which supports consideration of ethical issues in a range of healthcare settings. These include the four principles of autonomy, justice, beneficence, and nonmaleficence.

The principle of autonomy is the right to choose for oneself what one believes to be in one's best interests. The rights to privacy, truth telling, and confidentiality are also duties that evolve from this principle. One of the ethical dilemmas identified in this study was related to the issue of sharing information on the student's previous clinical performance with subsequent preceptors. Preceptors, however, have a legal and ethical duty to maintain confidentiality. Although it is acknowledged that such information may assist the next preceptor to foresee student needs and to plan appropriate learning

activities for them, sharing student information violates the ethical standards of confidentiality and a students' right to privacy (Duffy, 2004; Gaberson & Oermann, 1999; Verma & Patterson, 1998). Sharing such information may also interfere with the principle of justice or fairness during the evaluation process.

Preceptors have a moral obligation to evaluate students accurately and objectively (Harding & Grieg, 1994). The ethical principle of justice refers to fair treatment or judging everyone's behaviour by the same standards. In preceptorship experiences, justice implies that the preceptor should treat students with fairness and respect. They must be fair in the decision-making and evaluation processes (Chasen, et al. 2000). As well, preceptors must make sure that students' right to due process have been protected. This means informing students of the course requirements, of their responsibilities, and of their progress throughout the practicum (DeYoung, 2003). In addition, to earn a negative rating, students must have shown similar errors in their judgement over a period of time, without significant improvement. Students must also have had their errors or evidence of poor clinical performance brought to their attention previously. Preceptors should ensure that students have been given an adequate amount of time to overcome their performance problems prior to the final evaluation decision (Myrick & Yonge, 2005). They must also ensure fairness and maintain privacy and human dignity in providing feedback. The preceptors in this study stressed the importance of giving honest and constructive feedback to both students and instructors and the necessity to communicate the specific areas that need improvement.

The principle of beneficence is the duty to benefit others. A central belief reflected in this principle is the duty or obligation to assist others, to contribute to their

welfare, and, in doing so, to always act in the best interests of the patient. Applying the ethical principle of beneficence to clinical teaching and evaluation in the preceptorship experience means that students have a right to expect that their preceptors are competent, accountable, and knowledgeable (Gaberson & Oermann, 1999; Orchard, 1994; Theis, 1988). Orchard, for example, stated that students have the right to expect not only that their preceptors will follow policies and procedures, but also that they will be competent (Orchard, 1994). Competent instructors must be experts in their area of practice and possess an appropriate teaching background. An effective preceptor, like a clinical teacher, must be competent in (a) facilitating and supporting students in their learning activities, and (b) in evaluating student performance, including giving specific, timely feedback (DeYoung, 2003; Gaberson & Oermann, 1999; Reilly & Oermann, 1992). However, some preceptors in this study indicated that they had given the benefit of the doubt to weak students because of their lack of experience and confidence. This implies the ethical principle of beneficence was being jeopardized.

Although preceptors are expected to be accountable for evaluating students, the literature acknowledged that most preceptors have little or no experience in the evaluation role (Coates & Gromley, 1997; Dibert & Goldenberg, 1995; Hrobsky & Kersbergen, 2002; Scanlan et al. 2001; Yonge, Krahn, & Trojan, 1997). Kogan (as cited in Harding & Greig, 1994) suggested that those held to account cannot be so held if they lack the authority and resources such as knowledge, skills, attitudes, past experience, professional judgement, and time. Similarly, Lynch (as cited in Harding & Greig, 1994) asserted that "it is morally wrong to expect anyone to be answerable for activities which they have not been taught nor possess the skill" (p. 121). Thus, it can be argued that

novice preceptors may not be suitable as evaluators. This finding, like others from previously cited studies, highlights the need for preceptors to be adequately prepared so that they may be truly accountable for the evaluation of students.

The principle of nonmaleficence is the duty to do no harm and to protect others from harm. The principle to "do no harm" includes attention to (a) meaningful communication between persons, (b) professional standards of care, (c) the maintenance of professional competence, and (d) accurate, evidence-based assessments of risks and benefits (Arshall-Henty & Vernon, 2003). For example, before giving weak students the benefit of the doubt, preceptors must weigh the benefits against the risks of that action and include all relevant factors. The risk should never be greater than the importance of the problem to be solved (Cherry & Jacob, 2002).

Some preceptors in this study suggested that other preceptors are reluctant to fail students for fear of being labelled a 'bad person' by other staff or students. Others proposed that students are given the benefit of the doubt because of complacency or laziness on the part of the preceptor. Preceptors must realize that it is morally wrong or unethical for them to give a pass mark if a student does not deserve it. Failing to fail students compromises the standards of care and, ultimately, the reputation and status of the profession and the public's confidence in nurses a view that one of the preceptors in this study supported:

> When you are saying this person is qualified to be a nurse, you are saying this person is okay to go out there and do unsafe practice; and if you do that, then you are not caring for your patient and you are not taking safety into consideration.

Preceptors who pass unsafe students regardless of their performance are being unfair both to their colleagues, who will have to constantly watch over their team members, and to

the new graduates, who might ultimately be dismissed or, worse, lose their registration and career.

Accountabilities for Faculty/Instructors

As Figure 4 illustrates, nursing faculty or instructors have a multiplicity of accountabilities (Kopala, 1994; Parrott, 1994; Valiga & Streubert, 1991). Kopala (1994) asserted that nursing faculty "face conflicting obligations to students, patients, and agencies or institutions that require weighing and prioritizing values and choosing a course of action" (p. 236). Society demands that universities and faculty be accountable for preparing competent, safe practitioners who can, in turn, be held accountable for their own practice. Thus accountability for safe practice is shared by the institutions (universities and health care agencies), the faculty/preceptor, and the student (Parrott, 1993). Universities or colleges have contracts with many health care agencies in which students practice their skills. These contracts require that faculty assign, teach, and supervise the clinical practice of the students to guarantee patient safety.

Faculty members have an additional accountability to students. They must assure that students have the necessary learning experiences to prepare them to become competent practitioners. As well, nursing faculty are accountable to the agencies in which students and faculty have their clinical experience, to the parents who spend large amounts of money to pay for the students' education, to society, and to the profession of nursing that they serve (Valiga & Streubert, 1991).

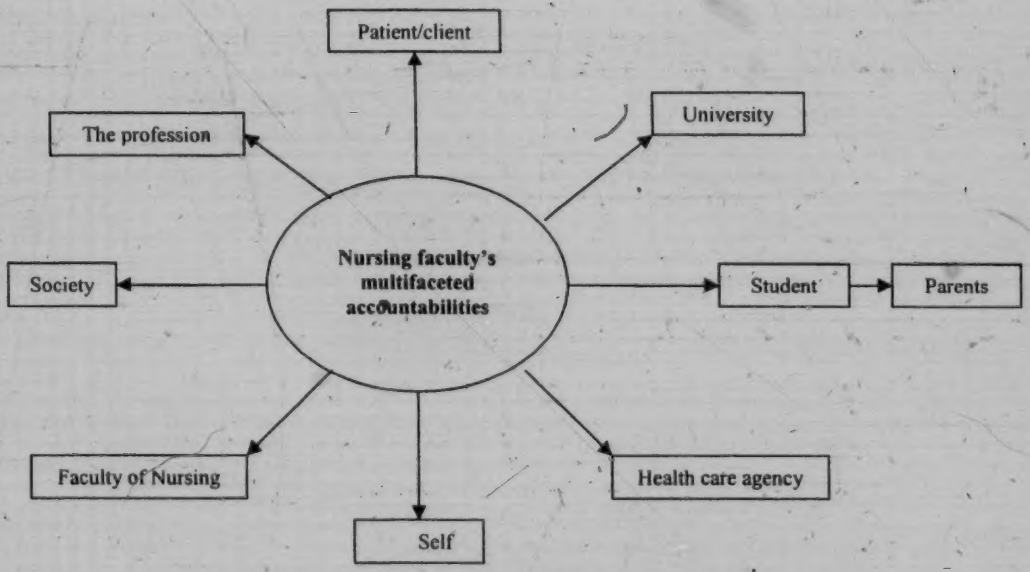

Figure 4. Faculty and their multifaceted accountabilities in the preceptorship experience.

The results of this study reveal that some students are ill prepared for their preceptorship experience. The preceptors commented that when most students start their preceptorship, they still lack basic clinical skill because the university nursing programs place more emphasis on theory than on the practical aspects of the curriculum. They also believed that the kind of teaching approach or program offered by the university and the short clinical placements do not offer enough experience for actual clinical practice. The preceptors contended that students can be unsafe because they lack the knowledge base to carry out some of the basic skills. They reported that medication errors are common among students, which they attributed to the fact that student programs do not offer pharmacology courses to students. Thus, faculty, to the extent possible, must ensure that students possess the required knowledge, skills, and competencies before being placed in

preceptorship programs and being allowed to graduate from nursing programs (CNA, 2002).

As the custodians of the teaching and learning process, faculty members are vital to the success of the preceptorship experience (Myrick & Yonge, 2005); they have the responsibility to be actively involved in the learning process and to offer support and guidance to both students and preceptors. To fulfill their responsibility as resource people, faculty members should make themselves available and accessible to the preceptors and students at all times throughout the preceptorship experience (Myrick & Yonge, 2005). The results of this study reveal that faculty members or instructors have a very important role, especially when preceptors are dealing with students who are struggling during their practicum. However, most of the preceptors in this study reported infrequent visits or contact with instructors. This lack of availability may be interpreted as neglect of academic duties and/or inadequate clinical guidance and support for preceptors and students—behaviours that violate the principle of beneficence (Theis, 1988).

Accountabilities for Students

Dishonesty, arrogance and disrespectfulness, and lack of due diligence (carelessness, laziness, and failure to follow through on management plans) are examples of unprofessional behaviour (Duff, 2004). Honesty is the foundation upon which professional reputations are built and upon which trust and meaningful communications are developed between people. Mutual trust forms the basis for effective preceptor-student relationships, and dishonesty can damage a preceptor's trust in students (Gaberson & Oermann, 1999). Yet, one third of the preceptors in this study identified

behaviours related to dishonesty as unprofessional. One preceptor recalled, "Her big thing was her lying techniques—'Yes, I checked it'—but she put it in the wrong bag. I mean, it was a mistake; it can happen. But there wasn't the honesty to own up for anything." Another preceptor reported, "She lied to me; she never told me; she withheld that information from me, and this went on for two or three days." Acts of dishonesty violate the ethical standard of veracity. Students, like nurses, have the responsibility to conduct themselves honestly and to protect their personal integrity in all of their professional interactions (CNA, 2002).

The ethical principles of autonomy, justice, beneficence, and nonmaleficence, as well as the ethical standards of respect for human dignity, veracity, and fidelity, are all important considerations for everyone involved in the preceptorship experience. It is therefore imperative that students learn to apply these principles and standards to nursing practice. As well, faculty and preceptors must apply them in their relationships with students as well as in their teaching and evaluation responsibilities.

Summary

This chapter has discussed the five major categories that emerged from the data analysis: hallmarks of unsafe practice, factors that contribute to unsafe practice, preceptors' perceptions and feelings, grading issues, and strategies for managing students with unsafe practices. The preceptors acknowledged that precepting students with unsafe practices can be difficult, frustrating, and time consuming because of the extra time involved in teaching, guiding, and evaluating them. They identified behaviours related to a lack of knowledge and skills, negative attitudes, and poor communication as "hallmarks of unsafe practice" and cited a variety of factors that contribute to students' unsafe

practice, including personal and professional stress, the learning environment, and the students' educational experiences. The main concern or dilemma for preceptors in this study was the competing demands of promoting student learning and preserving patient safety. The findings support the idea that if preceptorship programs are to succeed, both students and preceptors need to be adequately prepared and supported in their roles. Preceptors need support, concrete guidelines, and assistance in the process, especially when they are dealing with students whom they do not feel comfortable in passing.

Some of the issues, challenges, and dilemmas associated with precepting students with unsafe practices have been revealed in this study. Most of the challenges that the preceptors in this study face have been highlighted in the international and interdisciplinary literature (Dudek et al., 2005; Duffy, 2004; Duke, 1996; Hawe, 2003; Hayes et al., 1999; Hendrickson & Kleffner, 2002; Hrobsky & Kersbergen, 2002; Ilott & Murphy, 1997; Langlois & Thach, 2000a; Scanlan et al., 2001; Shapiro et al., 2002; Verma & Patterson, 1998). Some of the findings in this study have not previously been raised in the nursing literature, including issues such as the large number of theoretical assignments that are required during the final practicum as a contributory factor to unsafe practice, the current nursing shortage as the reason that students are passed even when there is doubt about their clinical performance, the effectiveness of CBL as a teaching/ learning approach, and after-degree programs as preparation for preceptorship experience. Although the literature highlighted the fear of legal implications as one of the reasons for the failure to fail students, none of the preceptors in this study raised such a concern.

Several strategies for responding to students who display unsafe practices have been considered. However, the participants saw identifying and intervening with students with unsafe practices early as a crucial process in dealing with such students. Although the number may be minimal, they still require a considerable amount of instructional time and resources. In this era of increasing demands and diminishing resources, the investment of time and resources to work with students who demonstrate unsafe practices needs to be addressed.

CHAPTER 6:

SUMMARY, CONCLUSIONS AND IMPLICATIONS

Summary and Conclusions

The purpose of this study was to construct a grounded theory to explain the social-psychological processes involved in precepting a student with unsafe practice and to identify effective management and coping strategies that preceptors use. The sample was comprised of preceptors involved in the final year of undergraduate and after-degree nursing programs. The preceptors in this study described precepting students as an interesting and rewarding experience, but they also acknowledged that it is demanding and challenging, particularly in regard to the extra time that they spend on preparation, supervision, and feedback.

This study has revealed that at some point during their experience with undergraduate nursing students, preceptors do have encounters with students who display unsafe practices during preceptorship placements. The study has also highlighted the challenges and dilemmas that preceptors currently face in working with such students. The main challenge for preceptors is to promote student safety and preserve patient safety. The preceptors in this study have found it difficult to balance the need to closely supervise students with the need to encourage students to develop clinical independence. Although this might be true for all preceptorship experiences, it is particularly challenging when the preceptor judges the student as untrustworthy or unsafe. Managing conflicting roles and responsibilities was another major challenge that these preceptors encounter in fulfilling their role.

The study also revealed that identifying and intervening early with students who display unsafe practices is crucial in the clinical setting. To identify unsafe practice, the preceptors must recognize the "red flags" or hallmarks of unsafe clinical performance. Behaviour or attitudes that alert preceptors to be more observant of possibilities of unsafe practice relates primarily to students' inability to demonstrate knowledge and skills, poor communication skills, and unprofessional behaviour.

The study findings suggest that students are not receiving enough practical skills or basic knowledge from the university program. There was a common concern among the preceptors about the level of student ability to perform what they perceived as basic nursing skills, such as drug administration. They reported that medication errors are very common among nursing students. This is a significant finding that requires further exploration because failure to calculate doses accurately could lead to drug errors, with potentially fatal consequences.

Nursing faculty must ensure that students possess the required knowledge, skills, and competencies to enrol in the preceptorship program. This implies that students need to be adequately prepared and assessed for their readiness for the preceptorship experience. Selecting suitable students for preceptorship is important to ensure client safety and student achievement of course objectives and to minimize the burden on the preceptor.

The study also affirmed that attitudinal problems such as acute defensiveness, an unenthusiastic attitude toward learning or work, and a "cocky," "know-it-all" attitude are particularly challenging for preceptors. The preceptors in this study contended that unmotivated students and those who are not receptive to feedback are the most difficult to

work with. They also considered behaviour such as dishonesty, lack of confidence, or extreme nervousness as unprofessional and unsafe and identified a variety of factors that contribute to students' unsafe practice, including personal and professional stress, the learning environment, their educational experiences, and language barrier.

The other concern that the preceptors highlighted in this study that would be worthy of further investigation is that the university nursing program places greater emphasis on theoretical assignments than on clinical practice. The issue of students' spending time studying for their theoretical exams or writing assignments during their practicum hours deserves further exploration to determine the impact on students and whether students in other professional programs also write assignments during their practical experience or at the completion of their experience.

This study affirmed that preceptors are aware that some students are passing their clinical practicum without having gained adequate clinical experience, which implies that preceptors in future placements have to contend with incompetent students or new graduates.

Another related issue is the reluctance of preceptors to assign failing grades for poor performance or to communicate negative feedback. The preceptors cited several reasons for their reluctance to fail a student, including a lack of experience or confidence; others admitted passing students because they did not want to jeopardize the students' future, especially when they were so close to graduating.

They also revealed that failing a student requires confidence, experience, and adequate preparation. The tendency of preceptors to pass students when a fail is warranted clearly indicates that ongoing professional development and adequate support

are required. Preceptors need support, concrete guidelines, and assistance on what to do when they are dealing with a student whom they do not feel comfortable in passing.

This study reveals that preceptors face a number of personal challenges in working with and evaluating students with unsafe practices that support from instructors in such situations is vital, and that failure can have emotional consequences for both the student and the preceptor. Students' emotions may vary from being upset to being angry, and they can be intimidating and or project blame onto others. Preceptors may be left with feelings of anger, frustration, anxiety, self-doubt, or relief. Others may be angry or disappointed with other colleagues who 'failed to fail' the student on previous placements.

Another issue raised in this study was that sometimes instructors assign students' final grades without the preceptor's evaluative comments. However, although the preceptors believed that instructors take their evaluative comments into consideration when they determine the final grade, they wondered whether students might think otherwise. This concern requires careful consideration to avoid preceptors' feelings of betrayal by the educational system and their complete withdrawal from precepting students.

Also highlighted in this study was the need for more effective communication between the school and preceptors. There should be continued contact with preceptors to ensure that they are kept informed of the final outcome if they have been involved with a marginally competent or failing student. Emphasizing strategies of being supportive and following up after the experience enhances the collaborative relationship with the preceptor.

This study has also suggested several strategies that preceptors can use in working with students who display unsafe practices in the clinical setting. These include, but are not limited to, being familiar with the course expectations; sharing expectations; identifying hallmarks of unsafe practice early; exploring and intervening with the student early; encouraging students to evaluate their performance; documenting carefully; developing a plan of action; observing vigilantly and allowing gradual clinical independence; creating a supportive environment; giving regular, honest, and constructive feedback; seeking guidance from a more experienced preceptor or instructor; providing remedial interventions; and recognizing that some students need to fail.

In conclusion, the researcher also hope that the results of this study may provide data for university faculty and administration to consider in exploring issues that may require adjustments in curriculum. As well, given the impact of the aforementioned challenges on students, preceptors, and educational programs, working effectively with students with unsafe practices deserves significant consideration. The researcher hopes that the results of this study will highlight an issue that deserves further exploration.

Implications

Implications for Nursing Education

The findings of this study have a number of implications for the planning of preceptorship programs and management of nursing students who display unsafe practices in preceptorship placements. These include the identification and implementation of proper screening of students prior to placement, the early detection of students whose level of practice is marginal, the development of strategies for dealing with such students, and appropriate support for preceptors who work with these students.

First, the results of this study suggest the importance of student preparation and readiness for the preceptorship experience. The preceptors felt that students are not adequately prepared for their preceptorship experience. Therefore, it is suggested that students be carefully screened and adequately prepared before being placed in preceptorship programs. This may require some adjustment in the preceptorship course that is currently included in the university program to ensure that students are adequately prepared. Selecting suitable students for the preceptorship experience is crucial to ensuring patient safety and student achievement of the course objectives and minimizing the burden on both the preceptor and the instructor. Students with marked deficits in basic skills, knowledge, motivation, and communication skills should not be placed until these deficits have been corrected (Yonge et al., 2002a).

Second, the findings also suggest that the kind of learning environment in which students are placed can contribute to unsafe practice and that the acceptance of clinical staff also directly impacts students' learning in the clinical setting. Therefore, it is suggested that during the planning and implementation of the preceptorship experience, careful assessment of the clinical settings to which students are assigned should be limited not only to the availability of the relevant experience, but also to the clinical staff's receptiveness to student placement (Myrick & Yonge, 2002).

Third, it is suggested that unsafe students be identified early in the placement so that they can be given the chance to improve. Preceptors could use the descriptions of unsafe and unprofessional behaviour in this study to identify early warning signs of poor performance or unsafe practices. Ongoing support and workshops also need to be in place to improve preceptors' confidence in identifying and assisting students. As well, it must

be impressed upon preceptors that they are responsible for identifying and fostering behaviour that is consistent with the expectations of the profession and for modeling this behaviour.

Fourth, the study findings reveal that the role of the instructor or faculty is crucial to the success of the preceptorship experience. The preceptors affirmed that they are more likely to make critical decisions on students' clinical performance when they are supported by instructors. Therefore, it is suggested that instructors avail themselves regularly and assume a more active role in the preceptorship experience to guide and support both students and preceptors as they progress through these challenging teaching/learning situations. It is also recommend that instructors continuously monitor the preceptorship experience by holding regular meetings with the preceptors, students, and staff in the clinical setting. Furthermore, the researcher recommends continued contact with preceptors to ensure that they are kept informed of the final outcome if they have been involved with a weak, unsafe, or failing student.

Fifth, the study findings also demonstrate that colleagues are regarded as important people with whom preceptors can discuss problems about students. Apart from the preceptorship workshops, it is suggested that opportunities be created and formalized in the form of forums, networks, or support groups in which preceptors can meet and share experiences of dealing with students with unsafe practices.

Sixth, the findings reveal evidence of reluctance among preceptors to assign failing grades for poor performance or communicate negative feedback. Because of their lack of experience in their role, some preceptors are reluctant to fail students even when a failing grade is warranted. Most of the preceptors in this study had not been adequately

prepared for their role, and it is suggested that preceptor orientation and preparation be strengthened. In fact, one preceptor in this study suggested that preceptorship workshops should be offered more often. Preceptors need ongoing feedback and support from instructors in areas such as assessing students and providing negative feedback.

It is suggested that preceptors be made aware of and held accountable for the potential professional consequences of 'failing to fail' (Duffy, 2004). Preceptors and faculty must also be reminded of their responsibility regarding marginally competent students, with a particular emphasis on the fact that failure early in the program is probably preferable to failure at the completion of the program.

It is suggested that the preceptorship workshops include the topic of dealing with an unsafe student as well as the emotional reactions associated with a failure scenario (Duffy, 2004). Issues such as conflict resolution and the evaluation process must be given more prominence during the preceptorship workshops.

The findings of this study also reveal that professional behaviour includes demonstrating skills that are expected of a professional nursing graduate. The preceptors claimed that inappropriate behaviour in any of the three domains of learning—cognitive, psychomotor, and affective—can contribute to unsafe practice and potentially affect the quality of patient care in the clinical setting. It is therefore suggested that learning outcomes pertinent to professional behaviour and attitude be given prominence in clinical evaluation tools. The researcher also recommend that nursing programs provide policies to address inappropriate behaviours and that these policies be communicated to students and reinforced.

Last, it is suggested that the issue of passing on information from one placement to the next once a student has failed a clinical assessment be explored and that policies, if available, be communicated to the preceptors.

Implications for Future Research

Until now there has been very little research in the area of management of students with unsafe practices. This study has made an important start, but there is a long way to go. It is suggested that the issue of unsafe practice among students be further explored within nursing programs. The study findings reveal that medication errors are very common among nursing students and that students are not currently being taught basic courses such as pharmacology. The researcher recommends conducting research to determine the prevalence of medication errors and the contributing factors apart from the omission of pharmacology in the current curriculum.

In conclusion, the preceptors in this study recognized that students with unsafe practices present a number of challenges and dilemmas to the preceptorship program. They indicated that early identification and intervention might be helpful in managing such students. As well, careful assessment of unsafe students can help to safeguard patients, professional standards, and the general public. Inevitably, therefore, it is important to realize that some students will not be able to meet the required level of practice.

REFERENCES

Alberta Association of Registered Nurses (1999). *Professional Conduct: Nursing practice.* Retrieved April 27, 2004, from http://www.nurses.ab.ca/profconduct/npa.html.

Allen, C. (2002). Peers and partners: A stakeholder evaluation of preceptorship in mental health nursing. *Nurse Researcher, 9*(3), 68-84.

American Nurses Association (ANA). (1997). Position statement: The right to accept or reject an assignment. Retrieved May 12, 2006, from http://www.nursingworld.org/readroom/position/workplac/wkassign.htm

Anders, R. (2001). Feedback without fear. *The Association of Perioperative Registered Nurses (AORN) Journal, 74*(6), 882-884.

Anderson, S. L. (1991). Preceptor teaching strategies: Behaviours that facilitate role transition in senior nursing students. *Journal of Nursing Staff Development, 4,* 171-175.

Arnold, W. K., & Nieswiadomy, R. M. (1997). A structured communication exercise to reduce nursing students' anxiety prior to entering psychiatric setting. *Journal of Nursing Education, 36*(9), 446-447.

Arshall-Henty, J., & Vernon, P. D. (2003). *Mosby's Canadian comprehensive review of nursing* (2nd ed). Toronto, ON: Mosby.

Atkins, S., & Williams, A. (1995). Registered nurses' experiences of mentoring undergraduates. *Journal of Advanced Nursing, 21*(5), 1006-1015.

Bashford, C. W. (2002). Breaking into orthopedic nursing: Preceptorship for novice nurses. *Orthopedic Nursing, 21*(3), 14-20.

Battersby, D., & Hemming, L. (1991). Clinical performance of university nursing students. *The Australian Journal of Advanced Nursing, 9*(1), 30-34.

Beck, C. T. (1993a). Nursing students' initial clinical experience: a phenomenological study. *International Journal of Nursing Studies, 30*(6), 489-497.

Beck, C. T. (1993b). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research, 15*(2), 263-266.

Benton, D. C. (1996). Grounded theory. In D. F. S. Cormack (Ed.), *The research process in nursing* (pp 123-134). Oxford: Blackwell Science.

Benzie, D. (1998). The difficult teaching situation. *Family Medicine, 30(*8), 549-550.

Bergman, K., & Gaitskill, T. (1990). Faculty and student perceptions of effective clinical teachers: An extension study. *Journal of Professional Nursing, 6*(1), 33-44.

Beuchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical Ethics* (5th ed.). Oxford: Oxford University Press.

Bick, C. (2000). Please help! I'm newly qualified. *Nursing Standard, 14*(16), 44-47.

Blainey, C. G. (1980). Anxiety in the undergraduate medical-surgical clinical students. *Journal of Nursing Education, 19*(8), 37-38.

Blais, K., & Bath, J. (1992). Drug calculation errors of baccalaureate nursing students. *Nurse Educator, 17*(1), 12-15.

Bliss-Holtz, J. (1994). Discriminating types of medication errors in nursing practice. *Nursing Research, 43*(6), 373-375.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method.* Englewood Cliffs, NJ: Prentice Hall.

Bodgan, R., & Biklen, S. (1998). *Qualitative research for education* (3rd ed.). Boston: Ally & Bacon.

Boley, P., & Whitney, K. (2003). Grade disputes: Considerations for nursing faculty. *Journal of Nursing Education, 42*(5), 198-203.

Bowles, N. (1995). A critical appraisal of preceptorship. *Nursing Standard, 9*(45), 25-28.

Brooke, P.S. (1994). Comment on Orchard's "clinical evaluation procedures". *Journal of Nursing Education, 33*(4), 252-253.

Brown, B., Mathew-Maich, N., & Royle, J. (2001). Fostering reflection and reflective practice. In E. Rideout (Ed.), *Transforming nursing education through problem-based learning* (pp. 118-163). Boston: Jones & Bartlett.

Bullock, S., & Manias, E. (2002). The educational preparation of undergraduate nursing students in pharmacology: A survey of lecturers' perceptions and experiences. *Journal of Advanced Nursing, 40*(1), 7-16.

Burgess, R., Phillips, R., & Skinner, K. (1998). Practice placements that go wrong. *Journal of Practice Teaching, 1*(2), 48-64.

Burns, N., & Grove, S. K. (1995). *Understanding nursing research.* Philadelphia: W. B. Saunders.

Burton, A. J. (2000). Reflection: Nursing's practice and education panacea? *Journal of Advanced Nursing, 31*(5), 1009-1017.

Byrne, G., & Heymen R. (1997). Understanding nurses' communication with patients in accident and emergency departments using a symbolic interactionist perspective. *Journal of Advanced Nursing, 26*(1), 93-100.

Caldwell, L., & Tenofsky, L. (1996). Clinical failure or clinical folly? A second opinion on student performance. *Nursing & Health Care Perspectives, 17*(1), 22-25.

Calman, L., Watson, R., Norman, I., Redfern, S., & Murrells, T. (2002). Assessing practice of student nurses: Methods, preparation of assessors, and student views. *Journal of Advanced Nursing, 38*(5), 516-523.

Canadian Nurses Association. (2002). *Code of ethics for registered nurses*. Retrieved April 5, 2004, from http://www.nurses.ab.ca/profconduct/ethics.html

Carlisle, C., Luker, K. A., Davies, C., Stilwell, J., & Wilson, R. (1999). Skills competency in nurse education: Nurse managers' perceptions of diploma level preparation. *Journal of Advanced Nursing, 29*(5), 1256-1264.

Chambers, M. A. (1998). Some issues in the assessment of clinical practice: A review of literature. *Journal of Clinical Nursing, 7*(3), 201-208.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. T. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage.

Cherry, B., & Jacob, S.R. (2002). *Contemporary nursing: Issues, trends, & management* (2nd ed.). St. Louis: Mosby.

Chickerella, B. G., & Lutz, W. J. (1981). Professional nurturance: Preceptorships for undergraduate nursing students. *American Journal of Nursing, 81*(1), 107-109.

Clancy, J., McVicar, A., & Bird, D. (2000). Getting it right? An exploration of issues relating to the biological sciences in nurse education and nursing practice. *Journal of Advanced Nursing, 32*(6), 1522-1532.

Clark, J. M., Maben, J., & Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Preparation for practice. *Journal of Advanced Nursing, 26*(2), 246-257.

Cleland, J., Arnold, R., & Chesser, A. (2005). Failing finals is often a surprise for students but not the teacher: Identifying difficulties and supporting students with academic difficulties. *Medical Teacher, 27*(6), 504-508.

Coates, V. E., & Gormley, E. (1997). Learning the practice of nursing: Views about preceptorship. *Nurse Education Today, 17*(2), 91-98.

College & Association of Registered Nurses of Alberta. (2005). *Professional boundaries for registered nurses: Guidelines for the nurse-client relationship.* Retrieved May 10, 2006, from http://www.nurses.ab.ca/pdf/Professional%20Boundaries%20Guidelines.pdf.

College of Nurses of Ontario. (2005). *Practice guideline: Supporting learner*. Retrieved April 27, 2006, from http://www.cno.org/docs/prac/44034_supportlearners.pdf

Corlett, J. (2000). The perceptions of nurse teachers, student nurses and preceptors of theory-practice in nurse education. *Nurse Education Today, 20*(6), 499-505.

Cowburn, M., Nelson, P., & Williams, J. (2000). Assessment of social work students: Standpoint and strong objectivity. *Social Work Education, 19*(6), 627-637.

Cresswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Crooks, D. L. (2001). The importance of symbolic interaction in grounded theory research on women health. *Health Care for Women International, 22*(1/2), 11-27.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing, 31*(6), 1476-1488.

Denzin, N. K., & Lincoln, Y. S. (Eds.), *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

DePaul University, Department of Nursing. (2001). *Student handbook: Unsafe and unethical nursing practice.* Retrieved October 25, 2003, from DePaul University Web site: http://condor.depaul.edu/~nursing/currentStudents/handbook.htm

DeYoung, S. (2003). *Teaching nursing*. Redwood City, CA: Addison-Wesley Nursing.

Dibert, C., & Goldenberg, D. (1995). Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptorship role. *Journal of Advanced Nursing, 21*(6), 1144-1151.

Diekelmann, N., & McGregory, A. (2003). Students who fail clinical courses: Keeping open a future of new possibilities. *Journal of Nursing Education, 42(10),* 433-436.

Dolan, G. (2003). Assessing student nurse clinical competency: Will we ever get it right? *Journal of Clinical Nursing, 12*(1), 132-141.

Dudek, N. L., Marks, M. B., & Regehr, G. (2005). Failure to fail: The perspectives of the clinical supervisors. *Academic Medicine, 80*(10 Suppl.), S84-S87.

Duff, P. (2004). Teaching and assessing professionalism in medicine. *Obstetrics and Gynecology, 104*(6), 1362-1366.

Duffy, K. (2004). *A grounded theory investigation of factors which influence the assessment of students' competence to practice.* London: Nursing and Midwifery Council.

Duke, M. (1996). Clinical evaluation: Difficulties experienced by sessional clinical teachers of nursing: A qualitative study. *Journal of Advanced Nursing, 23*(2), 408-414.

Dunn, S. V., & Hansford, B. (1997). Undergraduate nursing students' perceptions of their learning environment. *Journal of Advanced Nursing, 25*(6), 1299-1306.

Eaves, Y. D. (2001). A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing, 35*(5), 654-663.

Ellerton, M. L. (2003). Preceptorship: The changing face of clinical teaching. *Nurse Educator, 28*(5), 200-201.

English National Board of Nursing and Midwifery. (2001). *Preparation of mentors and teachers: A new framework for guidance.* London: English National Board.

Faculty of Nursing, University of Alberta. (2004a). *Fourth Year final Practicum Spring Summer course outline.* Edmonton: University of Alberta.

Faculty of Nursing, University of Alberta. (2004b). *Preceptor manual, Nursing 495.* Edmonton: University of Alberta.

Ferguson, L. M. (1994). Faculty support for preceptor nurses. *Nurse Educator, 19*(6), 6.

Ferguson, L. M., & Calder, B. (1993). A comparison of preceptor and educator valuing of nursing student clinical performance criteria. *Journal of Nursing Education, 32*(1), 30-36.

Ferguson, L. M. (1996). Preceptors' need for faculty support. *Journal for Nurses in Staff Development, 12*(2), 73-80.

Fitzpatrick, J. M., White, A. E., & Roberts, J. D. (1993). The relationship between nursing and higher education. *Journal of Advanced Nursing, 18*(9), 1488-1497.

Gaberson, K.B. (1997). Academic dishonesty. *Nursing Forum, 32*(3), 14-20.

General Faculties of Council. (2003). *GFC policy manual: Code of student behaviour.* Retrieved April 4, 2004, from the University Secretariat, University of Alberta Web site: http://www.ualberta.ca/~unisecr/policy/sec30.html

Glaser, B. G. (1978). *Theoretical sensitivity: Advanced in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Holton, J. (2004). Remodeling grounded theory. *Forum: Qualitative Social Research, 5*(2), Art. 4. Retrieved April 20, 2006, from http://www.qualitative-research.net/fqs-texte/2-04/2-04glaser-e.htm

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine de Gruyter.

Goldenberg, D., & Waddel, J. (1990). Occupational stress and coping strategies among female baccalaureate nursing faculty. *Journal of Advanced Nursing, 15*, 531-543.

Grandell-Niemi, H., Hupli, M., & Leino-Kilpi, H. (2001). Medication calculation skills of graduating nursing students in Finland. *Advances in Health Sciences Education, 6*(1), 15-24.

Grealish, L, & Carroll, G. (1998). Beyond preceptorship and supervision: A third clinical teaching model emerges for Australian nursing education. *Australian Journal of Advanced Nursing, 15*(2), 3-11.

Greenberger, H., Reches, H., & Riba, S. (2005). Do new graduates of registered nursing programs in Israel perceive themselves as technically competent? *The Journal of Continuing Education in Nursing, 36*(3), 133-140.

Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-118). Thousand Oaks, CA: Sage.

Guhde, J.A. (2003). English-as-a-second language (ESL) nursing students: Strategies for effective building verbal and written language skills. *Journal of Cultural Diversity, 10*(4), 113-117.

Hagler, P. & McFarlene, L. (1991). Achieving maximum student potential: The supervisor as coach. *Canadian Journal of Rehabilitation, 5*(1), 5-16.

Halloway, K. (1999). Developing an evidence base for teaching nursing practice skills in an undergraduate program. *Nursing Praxis in New Zealand, 14*(1), 22-32.

Hansen, H. (2000). *Unsafe nursing practice*. Retrieved May 27, 2004, from University of Tulsa, College of Business Administration, School of Nursing Web site: http://bus.cba.utulsa.edu/nsg3174/default.asp

Harding, C., & Greig, M. (1994). Issues of accountability in the assessment of practice. *Nurse Education Today, 14*(2), 118-123.

Haskvitz, L. M., & Koop, E. C. (2004). Students struggling in clinical? A new role for the patient simulator. *Journal of Nursing Education, 43*(4), 181-184.

Hawe, E. (2003). "It's pretty difficult to fail": The reluctance of lecturers to award a failing grade. *Assessment & Evaluation in Higher Education, 28*(4), 371-382.

Hayes, K. W., Huber, G., Rogers, J., & Sanders, B. (1999). Behaviors that cause clinical instructors to question the clinical competence of physical therapist students. *Physical Therapy, 79*(7), 653-667.

Hendrickson, W. D., & Kleffner, J. H. (2002). Assessing and helping challenging students: Part one: Why do some students have difficulty learning? *Journal of Dental Education, 66*(1), 43-61.

Hicks, P.J., Cox, S.M., Espey, E.L., Geopfert, A.R., Bienstock, J.L., & Erickson, S.S., et al. (2005). To the point: Medical education reviews - dealing with student difficulties in medical education. *American Journal of Obstetrics and Gynecology, 193*(6), 1915-1922.

Hills, N., Wolf, K. N., Bossetti, B., & Saddam, A. (1999). Preceptors appraisal of rewards and student preparedness in the clinical setting. *Journal of Allied Health, 28*(2), 86-90.

Hoyer, P. H., Booth, D., Spelman, M. R., & Richardson, C. T. (1991). Clinical cheating and moral development. *Nursing Outlook, 39*(4), 170-173.

Hrobsky, P. E., & Kersbergen, A. L. (2002). Perception of clinical performance failure. *Journal of Nursing Education, 41*(12), 550-553.

Hsieh, N., & Knowles, D. (1990). Instructor facilitation of the preceptor relationship in nursing education. *Journal of Nursing Education, 29*(6), 262-268).

Hunt, D. D., Carline, J., Tonesk, X., Siever. M., & Loebel, J. P. (1989). Types of problem students encountered by clinical teachers on clerkships. *Medical Education, 23,* 14-18.

Hutchinson, S. A. (1993). Grounded theory: The method. In P. L., Munhall & C. A. Boyd (Eds.), *Nursing research: A qualitative perspective* (pp. 180-212). New York: National League of Nursing Press.

Ilott, I. (1996). Ranking the problems of fieldwork supervision reveals a new problem: Failing students. *British Journal of Occupational Therapy, 59*, 525- 528.

Ilott, I., & Murphy, R. (1997). Feelings and failing in professional training: The assessor's dilemma. *Assessment and Evaluation in Higher Education, 22*(4), 307-316.

Infante, M. S. (1985). *The clinical laboratory in nursing education* (2nd ed.). New York: John Wiley & Sons.

Information and Privacy Office. (1999). *Freedom of Information and Protection of Privacy*. Retrieved February 6, 2005 from the University of Alberta Website: http://www.ipo.ualberta.ca/

Irby, D.M. (1994). What clinical teachers in medicine need to know. *Academic Medicine, 69*(5), 333-342.

Jackson, D., & Mannix, J. (2001). Clinical nurses as teachers: Insights from students of nursing in their first semester of study. *Journal of Clinical Nursing, 10*(2), 270-277.

Jalili-Grenier, F., & Chase, M. M. (1997). Retention of nursing students with English as a second language. *Journal of Advanced Nursing, 25*(1), 199-203.

Johantgen, M. A. (2001). Orientation to the clinical care unit. *Critical Care Nursing Clinics of North America, 13*(1), 131-136.

King, R. L. (2004). Nurses' perceptions of their pharmacology educational needs. *Journal of Advanced Nursing, 45*(4), 392-400.

Kleenhammer, K., Hart, A.L., & Keck, J. F. (1990). Nursing students' perceptions of anxiety-provoking situations in the clinical setting. *Journal of Nursing Education, 29*(4), 183-187.

Kleffner, J. H., & Hendrickson, W. D. (2001). Effective clinical teaching. Retrieved March 25, 2006 from http://cte.umdnj.edu/clinical_education/clined_general.cfm

Kopala, B. (1994). Conflict in nurse educators' role obligations. *Journal of Professional Nursing, 10*(4), 236-243.

Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality & Social Psychology, 77*(6), 1121-1134.

Lamberg, L. (2002). Long hours, little sleep: Bad medicine for physicians-in-training? *Journal of American Medical Association, 287*(3), 303-307.

Langlois, J.P., & Thach, S. (2000b). Managing the difficult learning situation. *Family Medicine, 32(5),* 307-309.

Langlois, J.P., & Thach, S. (2000a). Preventing the difficult learning situation. *Family Medicine, 32*(4), 232-234.

Lankshear, A. (1990). Failure to fail: The teacher's dilemma. *Nursing Standard, 4*(20), 35-37.

Laschinger, H. K. S., & MacMaster, E. (1992). Effects of pregraduate preceptorship experience on development of adaptive competencies of baccalaureate nursing students. *Journal of Nursing Education, 31*(6), 258-264.

Letizia, M., & Jennrich, J. (1998). A review of preceptorship in undergraduate nursing education: Implications for staff development. *The Journal of Continuing Education in Nursing, 29*(5), 211-216.

Lewis, K. E. (1990). University-based preceptor programs: Solving the problems. *Journal of Nursing Staff Development, 6*(1), 17-20, 28.

Lowry, J. S., Timms, J., & Underwood, D. (2000). From school to work: Employer perceptions of nursing skills. *Journal for Nurses in Staff Development, 16*(2), 80-85.

Lucas, J. H., & Stallworth, J. R. (2003). Providing difficult feedback: TIPS for the problem learner. *Family Medicine, 35*(8), 544-556.

Lyon, D. E., & Peach, J. (2001). Primary care providers' views of precepting new practitioner students. *Journal of the American Academy of Nurse Practitioners, 13*(5), 237-240.

Mackin, J., & Studva, K. (1997). An on-the-job preceptor model for newly hired nurses. In J. P. Flynn (Ed.), *The role of the preceptor: A guide for nurse educators and clinicians* (pp. 75-118). New York: Springer.

Mahara, M. (1998). A perspective on clinical evaluation in nursing education. *Journal of Advanced Nursing, 28*(6), 1339-1346

Manley, J. M. (1997). Adult learning concepts important to precepting. In J. P. Flynn (Ed.), *The role of the preceptor: A guide for nurse educators and clinicians* (pp. 15-46). New York: Springer.

Mayan, M. J. (2001). *An introduction to qualitative methods: A training module for students and professionals*. Edmonton, AB: Qual Institute Press.

McCann, T., & Clark, E. (2003a). Grounded theory in nursing research: Part 1: Methodology. *Nurse Research, 11*(2), 7-14.

McCann, T., & Clark, E. (2000b). Grounded theory in nursing research: Part 3: Application. *Nurse Research, 11*(2), 29-39.

McCarthy, M., & Higgins, A. (2003). Moving to an all graduate profession: Preparing preceptors for their role. *Nurse Education Today, 23*(2), 89-95.

Meisenhelder, J. (1987). Anxiety: A block to clinical learning. *Nurse Educator, 12*(6), 27-30.

Moeller, P. (1984). Clinical supervision: Guidelines for managing the problem student. *Journal of Allied Health, 13*(3), 205-211.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research, 5*(2), 147-149.

Morse, J. M. (2000). Determining sample size. *Qualitative Health* Research, *10(1),* 3-5.

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.).Thousand Oaks, CA: Sage.

Myrick, F. (1998). *Preceptorship and critical thinking in nursing education*. Unpublished PhD thesis, University of Alberta, Edmonton, AB.

Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *Journal of Nursing Education, 41*(4), 154-164.

Myrick, F., & Barrett, C. (1994). Selecting clinical preceptors for basic baccalaureate nursing students: A critical issue in clinical teaching. *Journal of Advanced Nursing, 19*(1), 194-198.

Myrick, F., & Yonge, O. (2001). Creating a climate for critical thinking in the preceptorship experience. *Nurse Education Today, 21*(6), 461-467.

Myrick, F., & Yonge, O. (2005). *Nursing preceptorship: Connecting practice and Education*. Philadelphia: Lippincott Williams & Wilkins.

Neary, M. (2001). Responsive assessment: Assessing student nurses' clinical competence. *Nurse Education Today, 21*(1), 3-17.

Nehls, N., Rather, M., & Guyette, M. (1997). The preceptor model of clinical instruction: The lived experiences of students, preceptors, and faculty-of-record. *Journal of Nursing Education, 36*(5), 220-227.

Noddings, N. (1984). *Caring: A feminist approach to ethics and moral education*. Berkeley, CA: University of California Press.

Nolan, C. (1998). Learning on clinical placement: The experience of six Australian students. *Nurse Education Today, 18*(8), 622-629.

Norman, I., Watson, R., Murrells, T., Calman, L., & Redfern, S. (2002). The validity and reliability of methods to assess the competence to practice of pre-registration nursing and midwifery students. *International Journal of Nursing Studies, 39*(2), 133-145.

Nylund, L., & Lindholm, L. (1999). The importance of ethics in the clinical supervision of nursing students. *Nursing Ethics, 6*(4), 278-286.

O' Mara, A. M. (1997). A model preceptor program for student nurses. In J. P. Flynn (Ed.), *The role of the preceptor: A guide for nurse educators and clinicians* (pp. 47-75). New York: Springer.

Oermann, M. H., & Garvin, M. F. (2002). Stresses and challenges for new graduates in hospitals. *Nurse Education Today, 22*(3), 225-230.

Öhrling, K., & Hallberg, I. R. (2000). Nurses' lived experience of being a preceptor. *Journal of Professional Nursing, 16*(4), 228-239.

Öhrling, K., & Hallberg, I. R. (2001). The meaning of preceptorship: nurses' lived experience of being a preceptor. *Journal of Advanced Nursing. 33*(4), 530-540.

Orchard, C. (1994). The nurse educator and the nursing student: A review of the issues of clinical evaluation procedures. *Journal of Nursing, 33*(6), 245-251.

Parrott, T. E. (1993). Dismissal for clinical deficiencies. *Nurse Educator, 18*(6), 14-17.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Peirce, A. G. (1991). Preceptorial students' view of their clinical experience. *Journal of Nursing Education, 30*(6), 244-250.

Pelletier, D. (1995). Diploma-prepared nurses' use of technological equipment in clinical practice. *Journal of Advanced Nursing, 21*(1), 6-14.

Phillips, E. (2002). Managing legal risks in preceptorships: What are the legal risks in preceptoring? *The Canadian Nurse, 98*(9), 25-26.

Phillips, S., & Hartley, J. T. (1990). Teaching students for whom English is a second language. *Nurse Educator, 15*(5), 29-32.

Polifroni, E. C., Allchin, L., & McNutty, J. J. (2005). Limited math skills: A prescription for change. *Journal for Nurses in Staff Development, 21*(2), 79-81.

Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Potter, P. A., & Perry, A. G. (2001). *Canadian fundamentals of nursing* (2nd ed.). Toronto, ON: Mosby.

Pulsford, D., Boit, K., & Owen, S. (2002). Are mentors ready to make a difference? A survey of mentors' attitudes towards nurse education. *Nurse Education Today 22*(6), 439-446.

Raudonis, B.M., & Acton, G.J. (1997). Theory-based nursing. *Journal of Advanced nursing, 26*(1), 138-45.

Rees, C., & Shepherd, M. (2005). Students' and assessors' attitude towards students' self-assessment of their personal and professional behaviours. *Medical Education, 39*(1), 30-39.

Rittman, M. R., & Osburn, J. (1995). An interpretive analysis of precepting an unsafe student. *Journal of Nursing Education, 34*(5), 217-221.

Robinson, A., McInerney, F., & Sherring, M. (1999). Developing a collaborative preceptor program involving registered nurses, student nurses, and faculty. *Australian Journal of Advanced Nursing, 17*(1), 13-21.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27-37.

Sayer, M. M., De Saintonge, M., Evans, D., & Wood, D. (2002). Support for students with academic difficulties. *Medical Education, 36*(7), 643-650.

Scanlan, J. M., Care, W. D., & Gessler, S. (2001). Dealing with unsafe students in clinical practice. *Nurse Educator, 26*(1), 23-27.

Schreiber, R. S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 55-83). New York: Springer.

Shapiro, D. A., Ogletree, B. T., & Brotherton, W. D. (2002). Graduate students with marginal abilities in communication sciences and disorders: Prevalence, profiles, and solutions. *Journal of Communication Disorders, 35,* 421- 451.

Sharp, M. (2000). The assessment of incompetence: Practice teachers' support needs when working with failing DipSW students. *Journal of Practice Teaching, 2*(3), 5-18.

Sharp, M., & Danbury, H. (1999). *The management of failing DipSW students*. Aldershot, UK: Ashgate.

Smith, M., McKoy, Y., & Richardson, J. (2003). Legal issues related to dismissing students for clinical deficiencies. *Nurse Educator, 26*(1), 33-38.

Souers, C. (2002). Comprehensive performance review preparing students for a preceptor experience. *Nurse Educator, 27*(1), 9-12.

Speers, A. T., Strezywski, N., & Ziolkowski, L. D. (2004). Preceptor preparation: An investment in the future. *Journal for Nurses in Staff Development, 20*(3), 127-133.

Stern, P. N. (1980). Grounded theory in nursing research. In M. M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 149-160). New York: Grune & Stratton.

Strauss, A. J., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Strauss, A. J., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Streubert, H. J., & Carpenter, D. R. (1999). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd ed.). Philadelphia: Lippincott.

Teekman, B. (2000). Exploring reflective thinking in nursing practice. *Journal of Advanced Nursing, 31*(5), 1125-1135.

Teeter, M. M. (2005). Formula for success: Addressing unsatisfactory clinical performance. *Nurse Educator, 30*(3), 91-92.

Theis, C. (1988). Nursing students' perspective of unethical teaching behviour. *Journal of Nursing Education, 22*, 102-106.

Timmins, F., & Kaliszer, M. (2002). Aspects of nurse education programmes that frequently cause stress to nursing students. *Nurse Education Today, 22*(3), 203-211.

Usher, K., Nolan, C., Reser, P., Owens, J., & Tollefson, J. (1999). An exploration of the preceptor role: Preceptors perceptions of benefits, rewards, supports, and commitment to the preceptor role. *Journal of Advanced Nursing, 29*(2), 506-514.

Valiga, T. M, & Streubert, H. J. (1991). *The nurse educator in academia: Strategies for success.* New York: Springer.

Van Hoozer, H. L., Bratton, B. D., Ostomoe, P. M., Weinholtz, D., Craft, M. J., Gjerde, C. L., et al. (1987). *The teaching process: Theory and practice in nursing.* Norwalk: Appleton-Century-Crofts

Vaughn, L. M., Baker, R. C., & DeWitt, T. G. (1998). The problem learner. *Teaching and Learning in Medicine, 10*(4), 217-222.

Vella, J. (2002). Twelve principles of effective adult learning. In J. Vella (Ed.), *Learning to listen, learning to teach: the power of dialogue in educating adults* (pp. 3-28). San Francisco: Jossey-Bass.

Verma, S., & Paterson, M. (1998). Evaluation of marginal students: A workshop for clinical faculty. *Journal of Allied Health, 27*(3), 162-166.

Watson, H. E., & Harris, B. (1999). *Supporting students in practice placements in Scotland.* Glasgow: Glasgow Caledonian University, Department of Nursing and Community Health.

Watson, J. (1988). *Nursing: Human science and human: A theory of nursing.* New York: National League for Nursing.

Wheeler, H. H., Cross, V., & Anthony, D. (2000). Limitations, frustrations, and opportunities: A follow-up study of nursing graduates from the University of Birmingham. *Journal of Advanced Nursing, 32*(4), 842-856.

White, E., Riley, E., Davies, S., & Twinn, S. (1994). *A detailed study of the relationship between teaching, support, supervision, and role modeling in clinical areas within the context of Project 2000 courses.* London: English National Board for Nursing, Midwifery and Health Visiting.

Wiseman, T. A. (1996). A concept analysis of empathy. *Journal of Advanced Nursing, 23*(6), 1162-1167.

Wolfe-Burke, M. (2005). *Clinical instructors' description of physical therapist student professional behaviours.* Retrieved December 10, 2005, from http://www.findarticles.com/p/articles/mi_qa3969/is_200504/ai_n13639980/pg_6

Yonge, O., Krahn, H., Trojan, L. R. & Reid, D. (1997a). Preceptors evaluating nursing students.*Canadian Journal of Nursing Administration, May-June,* 77-95.

Yonge, O., Krahn, H., Trojan, L.R, & Reid, D. (1997b). Through the eyes of the preceptor.*Canadian Journal of Nursing Administration, November-December,* 64-85.

Yonge, O., Krahn, H., Trojan, L., Reid, D., & Haase, M. (2002a). Being a preceptor is stressful. *Journal for Nurses in Staff Development, 18*(1), 22-27.

Yonge, O., Krahn, H., Trojan, L., Reid, D., & Haase, M. (2002b). Supporting preceptors. *Journal for Nurses in Staff Development, 18*(2), 73-79.

Yonge, O., & Myrick, F. (2004). Preceptorship preparatory process for undergraduate nursing students and their preceptors. *Journal for Nurses in Staff Development, 20*(6), 294-297.

Yonge, O., Myrick, F., & Haase, M. (2002). Student nurse stress in the preceptorship experience. *Nurse Educator, 27*(2)

APPENDIXES A AND B:

FOURTH-YEAR FINAL PRACTICUM COURSE OUTLINE

AND CLINICAL EVALUATION FORM

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APPENDIX C:

RECRUITMENT NOTICE

Appendix C: Recruitment Notice

The Challenges for Preceptors in Dealing with Nursing Students Engaging in Unsafe Practices

Research Study

Seeking Preceptors for final fourth year clinical practicum to
share their experiences of dealing with
a nursing student engaging in unsafe practices

My name is Florence Loyce Luhanga, a PhD nursing student and nurse educator interested in how preceptors of undergraduate nursing students deal with/ manage nursing students who engage in unsafe practices. My aim is to understand the process preceptors go through when precepting nursing students with unsafe practices. If you are a final fourth year clinical practicum nurse preceptor in the urban centre and you have preceptored on a nursing student with unsafe practices and would be willing to be interviewed for approximately 1 to 2 hours at your convenient time and place, outside your normal work schedule, please contact me at the following address for more details.

Investigator:
Florence L. Luhanga, RN, MEd, PhD (c)
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University of Alberta
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T6G 2G3
E-mail: fluhanga@ualberta.ca
Phone: (780) 461 7648 or (780) 708 2001

Supervisor:
Dr Olive Yonge, RN, PhD
Faculty of Nursing
3rd Floor Clinical Science Building
University of Alberta
Edmonton, AB
T6G 2G3
Phone: (780) 492 2402

APPENDIX D:

INFORMATION LETTER

Appendix D: Information Letter

Title of study The Challenges for Preceptors in Dealing with Nursing Students Engaging in Unsafe Practices

Investigator
Florence Loyce Luhanga RN, MEd, PhD (c)
Faculty of Nursing
3rd Floor Clinical Science Building
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T6G 2G3
Phone: (780) 461-7648 or (780) 708-2001

Supervisor
Professor Olive Yonge, RN PhD
Faculty of Nursing
3rd Floor Clinical Science Building
University of Alberta
Edmonton, AB
T6G 2G3
Phone: (780) 492-2402

Introduction

Dear preceptors. You are being invited to take part in research study. Before you decide, please take time to read the following information carefully, to understand why the study is being done and what it will involve. My name is Florence Luhanga. I am a nurse educator from Botswana, in Southern Africa, currently pursuing, a PhD in nursing in the Faculty of Nursing at the University of Alberta. The preceptorship model of clinical teaching and learning has been my area of interest since it was introduced into the nursing program, where I was teaching, and the area I have chosen for my PhD Thesis.

Background/purpose of the study

Although preceptorship programs are have grown in popularity very little is known about how preceptors teach students whose level of performance is unsafe, and even less is known about how preceptors manage students engaging in unsafe practices. In Alberta, Canada, the Nursing Education Program Approval Board requires that students have consolidated practice with a preceptor at the end of the program leading to licensure. Therefore, the purpose of this study is explore and understand the process the NURS 495 preceptors go through when preceptoring nursing students with unsafe practices. I believe that the information from this study will assist nurse educators and preceptors in their efforts to improve the quality of clinical teaching for nursing students in Canada.

Procedure

The investigator will collect data about how preceptors deal with nursing student who engage in unsafe practices in the following manner: First, if you decide to participate, you are likely to participate in only one individual interview, although later you may be asked to participate in a follow up interview to clarify findings or in cases of time or fatigue with the first interview, to get further data. The interview will last approximately 1 to 2 hours and arranged on a date and location convenient to both you and the investigator, and at a time outside your normal work schedule. All interviews will

be tape-recorded and notes taken by the investigator. Immediately after each interview, tape-recorded interviews, handwritten field notes will be transcribed and analyzed.

Privacy and confidentiality

The tapes and notes will be kept in a safe place (i.e. locked filing cabinet) and only the researcher will have access to them. No names or identifying information will appear in the reports. The final report of this study may include some of your words but your name or identifying information will appear. Your name will also not be used in any presentations or publications of the study results. The information you provide for this study will be stored in the Faculty of Nursing, at the University, for at least five years after the study has been completed

Consent

It is up to you to decide whether or not you want to take part in this study. If you decide to take part you will be asked to sign a consent form. All who will participate in this study will be expected to give voluntary consent. If you decide to take part you are may choose not to answer any of the questions or discuss any subject in the interview if you don't want to.

Freedom to withdraw

Your participation in this study is completely voluntary. If you decide to take part you may choose to withdraw from the study at any time and without giving a reason. If you decide to withdraw from the study, all collected data will be withdrawn and not included in the study. Your decision to withdraw will not affect your employment in any way.

Benefits

There will likely be no direct benefits from participating in this study. However, following completion of this study, it is possible the results will assist nurse educators and preceptors in their efforts to improve the quality of clinical teaching for nursing students in Canada.

Risks or Discomfort

There are no foreseen disadvantages or risks to taking part in this study. However, in the event that you show any signs of emotional distress pertaining to the questions I ask you, I will stop the interview and turn off the tape recorder. You will be asked if you would like to stop or to continue with the interview. You will also be asked what kind of support you would need and if required, I will refer you to an appropriate helper. At any time you feel you need to take a break or completely withdrawal from the study, you may do so.

Use of data

The transcripts or written notes will be reviewed only by the investigator, her thesis supervisors and transcriber. The tapes of the research interviews will be kept in a safe place (i.e. locked filing cabinet) for a minimum of 5 years. The researcher intends to

publish the results of this study in nursing journals and present them at professional conferences. A summary of the findings would be available to you upon request.

Future use data

The information gathered for this study may be reviewed again in the future to help us answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically.

If you would like more information about the study, or would be interested in participating, please complete the bottom of this form and return it in the attached, stamped envelope or call at 461-7648 and leave a message on the answering machine. I will contact you by phone to answer any questions.

Additional contacts

If you have any more questions, concerns or comments about this research study, you are free to contact Florence Luhanga at 780-461-7648 or my supervisor, Dr Olive Yonge at 780 492-2402. In addition, you may contact the Health Research Ethics Board at 780-492-0302 should you have any questions regarding your rights as a study subject. Thank you for reading this information sheet and your consideration.

Sincerely,

Florence Loyce Luhanga, RN, MEd, PhD (c)

I would like to be contacted for further information about participation in Florence Luhanga's study of 'the Challenges for Preceptors in Dealing with Nursing Students Engaging in Unsafe Practices'.

Name: _____
Phone number at home: _____ at work _____
Best time to telephone: _____

APPENDIX E:

CONSENT FORM

Appendix E: Consent Form

Title of project: The Challenges for Preceptors in Dealing with Nursing Students With Unsafe Practices

Investigator:
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Supervisor:
Dr Olive Yonge, RN, PhD
Faculty of Nursing
3rd Floor Clinical Science Building
University of Alberta
Edmonton, AB
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Phone: (780) 492 2402

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached information sheet?	Yes	No
Have you had an opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records/information?	Yes	No
Do you consent to be interviewed?	Yes	No
Do you consent to being audio-taped?	Yes	No
Do you agree to review your data at later date?	Yes	No
Do you agree that the investigator may revisit your data if relevant to future studies	Yes	No

This study was explained to me by: _____

I have read and understand the above information, and agree to participate in this study.

_____ _____ _____
Signature of Participant Printed Name Date

I believe that the person signing this consent form understands what is involved in the study and voluntarily accepts to participate.

_____ _____ _____
Signature of Participant Printed Name Date

APPENDIX F:

DEMOGRAPHIC DATA

Appendix F: Demographic Data

1. Code: ____

2. Date of Birth: Month ____ Year _____

3. Gender: Male __ Female __

4. Marital Status: Married __ Single __Other_____

5. Nursing Education and year graduated:

   Diploma _____
   Baccalaureate _____
   Masters _____
   Other _____

6. Post graduate Education:

7. Continuing education:

8. Total number of years of nursing education:

9. Years of experience in nursing:

10. Brief description of the current work experience and major responsibilities:

11. Total number of years as a preceptor:

12. Total number of students preceptored:

13. What levels of students have you preceptored?

14. Briefly describe how you were prepared for your role as a preceptor?

APPENDIX G:

SEMISTRUCTURED INTERVIEW GUIDE

Appendix G: Semistructured Interview Guide

The following questions will be used to guide the initial stage of the interview. This is a broad guide to areas that might be covered in the interview. However, care will be taken to avoid imposing too much structure on the interview, so that the quality data is not affected. In addition, subsequent question will be asked to clarify statements ideas, thoughts, and feeling and to gain a fuller understanding of the phenomenon under study.

1. Think of a student who was engaging in unsafe practice in a preceptorship experience with you. What was it like to be a preceptor dealing with a student who is engaging in unsafe practices?

2. What student actions, behaviours or attitudes would you identify as unsafe practice?

3. When did you realize there was a problem?

4. What did you do to help the students? Did you ask for external help? If so, why? Did it work?

5. How many students with unsafe practices have you encountered?

6. How do you think students with unsafe practices should be dealt with?

7. In your experience, do students sometimes pass clinical placements without having gained sufficient competence? (Watson & Harris, 1999; Duffy, 2004).